07 Te

'-06550	Please Type or Print in Black Indelible State of Maryland / Department	Ink. Ensure All Copie of Health and Mental H	vaiene	0.17: 5.50
erry Lynn Keesler 1	-For State Of Maryland / Department -For State Certificate	of Death	Reg. No.	007 2750
Physician/	egistrar I. Decedent's Name (First, Middle,Last)		Date of Death Month Day Year	3. Time of Death 0450 hrs
ledical Examiner	Terry Lynn Keesler	4b. City. Town, or Location of Death	Month Day Year August 24, 2007	
	ta. Facility Name (if not institution, give street and number) 8627 Liberty Road 2nd floor	Randallstown	Baltimore	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		-	9. Birthplace (State or Foreign
lulielai	10	Months Days Hours Min	AUG 26 1963	Country) MD
	Usual Residence of Decedent	cation		10d. Inside City Limits
≅ .				1 Yes 2 X No
th the Maryland 23a or 28a-f show notified at once.	MD Baltimore Randall	10f. Zip Code	10g. Citizen of Wha	it Country?
the Maryland a or 28a-f sh tified at once	8627 Liberty Road, 2nd floor	21133	USA	
5-0036 led within 72 hours after death with the Maryland Hygiene other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto		American Indian, Black, etc.
or items 23	1 Never Married 2 Married 1 Yes 2 X No	Yes 2X No specify:		White
ural".	or Dates:	dent's Usual Occupation (Give kind of	work done . 16b. Kind of Bus	
72 hour 12 hour 12 hour 14 Exa	Elementary/Secondary (0-12) College (1-4 or 5+)	g most of working life. DO NOT use re		~
within 72 hour siene. Medical Exau ompleted		stant Manager	Grocer (First, Middle, Maiden Sumame)	У
15-0 filed w I Hygin of other t, the I	17. Father's Name (First, Middle, Last)		ny Marie Starnes	
21215-0036 outche filed within 72 hours d Méntal Hygiene. s marked other than "naturite event, the Medical Exaturite of the Completed E	Robert William Keesler, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ailing Address (Street and Number or	Rural Route Number, City or Town	n, State, Zip Code)
MD 2 sho		27 Liberty Road, F	Randallstown, MD Date 20c. Location -	21133 City or Town, State
re, l	20d. Welliod of Disposition 2 Removed from State crematory of	sposition (Name of cemetery, or other place)		
imore Pages 1 ment of F tant: If i	Metro C	Crematory, Inc. 8/	24/200/ Baltim	ore, MD
Baltimore, I permit. Pages 1 and Department of Heak Important: If item injury or other tra	21. Signature of Funeral Service Licensee H. Williams	y of Maryland, bad, Baltimore,	Inc. MD 21228	
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not en	ter the mode of dying, such as cardiac	or respiratory arrest, shock, or hea	Between Onset and
Medical saminer	failure. List only one cause on each line. Immediate Cause (Final disease a. Pulmonary hemorrhage du	e to focal granuloma		Death
Sammer	or condition resulting in death) Due to (or as a consequence of):			
er	Sequentially list conditions, If any leading to immediate Due to (or as a consequence of):			
ed nsit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
ecuted of and transit	d			
be execusician and	X UNPENDED AMENDED #23a,PII,27,perME.g87	2. 10/31/07_TT	23d. Date of	delivery
tox 68760, eath certificate be ex eattending physician for use as the burial	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic preg		Day Year
x 68 th cert ttendir truse a	past 12 months? 4 Pregnant at time of death 5	Other (Specify)		
Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be earl as there death. The first and death. The fineral director, page 2 should be detached for use as the burial perification: To Be Completed by Physician/Medierification: To Be Completed by Physician/Medie	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use cont	ribute to the cause of death?
P.O es that gened be detailed by	pseudomembranous colitis; hypertension; d		1 Yes 2 No 3	
(ecords, Fine law requires are has been signage 2 should be ompleted			autopsy	Were autopsy findings available prior to completion of cause of death?
eco he law ate has age 2 s			performed? 1 ✓ Yes 2 No	Yes 2 No
tal R cian: T certifica rector, pa	25. Was case referred to medical examiner?	26.Place of Death (Che	-	✔ Other: Scene
F Vite	1 ✓ Yes 2 No Inpatient 2 ER/Outp	atient 3 DOA Other Nu ne of Injury 28c. Injury at Work?	rsing Home 5 Residence 6 28d. Describe how injury occur	
n of ding I	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	1 Yes 2 No		
isio Atten er deat rector i by thu	2 Accident Investigation 28e. Place of Injury - At home, farm	, street, factory, office building, etc.	28f. Location (Street and Num or Town, State)	ber or Rural Route Number, City
Division os spital or Attending nours after death. neral Director: After filled in by the fune Certification:	determined (Specify)			
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation.	occurred at the time, date and place, estigation, in my opinion, death occurred	and due to the cause(s) and manne ed at the time, date and place, and	er as stated. due to the cause(s)
To the Ho within 24 To the Fu completel	one) 2 Medical Examiner:On the basis of examination and/or live and manner stated. 29b. Signature and title of certifier	29c. License number		ned (Month, Day, Year)
	Dt. Onsa : Poloh	O.C.M.E.	August 24	4, 2007
	30. Name and address of person who completed cause of death (Item 23a)		14D 04004	
0	Patricia Aronica-Pollak MD. Assistant Medical Examir		nore, MD 21201	
State Registra		Sparle		

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / D		artment of F		and M		jiene	007	27503
かんか	Physici /Medio		1. Decedent's Name (First, Middle, Last) Elaine Helen Leckliter				- L	2. Date of Dea Month	-	Year 2007	3. Time of Death 5:35 A ^M
	Examir		4a. Facility Name (If not institution, give street and number) Future Care		4b. City, Town, or Clinton		f Death		4c. Co	ounty of Death	
100	Funeral Director		5. Social Security Number 217-44-6195 G. Sex 1	hday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Ceb. 21	. Year)	Cot	place (State or Foreign intry) nington, DC
	h the Maryland r 28a-f show notified at	Director	10a. State 10b. County 10c. City, Town VA King George King G 10e. Street and Number					1	10d. Inside City Limits 1 ☑Yes 2 ☐No 10g. Citizen of What Country?		
036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	by Funeral	5498 Rosedale Drive 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 1 □ Never Married 2 □ Married 2 □ Married 3 □ Married 3 □ Married 3 □ Married 3 □ Married 1 □ Marri		22485 Was Decedent of H If Yes, specify Cuba 1 □ Yes 2⊠ No	ispanic Oric an, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)		Race - Ameri Black, White	, etc.
121215-0036	led within 72 h lygiene. her than "natu nt, the Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 7	(Give life. [dent's Usual Occup kind of work done of DO NOT use retired omemaker	during most 1)			0	of Business/Ir	
Maryland	should be fil nd Mental H marked otl matic even	To Be	17. Father's Name (<i>First, Middle, Last</i>) William Birch 19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b.	Mailiu	ng Address (Street]	Eva N	(First, Middle, I Nalley			n Cade)
Baltimore, Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		Joanne Leckliter/Daughter K	Dispo y, crer nha ry	ng Address (Street of Rosedal) (Street of Rose	VA (e) (nS (ss of Facility	3/23/ y Bro	ookside	^{20c. Loca} Che1t Fune	tion - City or T cenham, cral Ho	own, State
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of	ot ent							Approximate Interval Between Onset and Death
8760,	ficate be executed a physician and burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of Cause (Disease or injury that initiated events resulting in death) Last		IRFAR 15104	Cīlo	~				
P.O. Box 68	ath cert	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		⊒Ectopic pregnancy ⊒ Other (specify)			23d. Date of delivery Month Day Y			
	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions contributing to death but not resulting in	the ur	nderlying cause give	en in Part I.					the cause of death? bably 4 □Unknown
Vital Records,		Completed	25. Was case referred to medical			00 Pl-			sy med? 2.∭ANo	prior to co death?	opsy findings available impletion of cause of 2 No
	g Physicia er this cert eral direct	n: To Be	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Out; 27. Manner of Death 28a. Date of Injury 28b. Ti	ime of		er: 4 🔀 Nur	rsing Hom	Check onl on ne 5 Reside 8d. Describe he	ence 6		fy)
Division or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, I	Certification:	1 ⊠ Natural 5 □ Pending (Month, Ďay Year) Inj 2 □ Accident investigation 3 □ Suicide 6 □ Could not be 4 □ Homicide determined 28e. Place of injury - At home, farr building, etc. (Specify)	ijury m, stre	M 1 🗆	<br Yes 2□N		8f. Location (S		Number or Rur	al Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dil completely filled in										stated. to the cause(s)
	To the within To the comple	Medical	29b. Signature and title of certifier M M M M M M M M M M M M M		29c. License	e number	9		Α	signed (Month	Day, Year) 2007
	37		30. Name and address of person who completed cause of death (Item 23a) (T	уре,	Print)	PAR	Kwi				
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 8 2007 32. Registrar's Signature	A	berte	1 1/1	-1				- Haland

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Physician *
/Medical
Examiner
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Physi /Med Exam

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

Division or Vital Records, P.O. Box 68760,

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	1 - State of Ma	aryland / Depa <i>Cei</i>	rtificate of D		-	iene 200	7 2750				
rsician ledical	Decedent's Name (First, Middle, Last) MAY EENBERG LETTS				2. Date of Deat Month AUGUST	Day 23, 2007	3. Time of Death 10:45 A M				
aminer eral etor	108-03-2707 1□M 2反F	CENTER le (In yrs. last birthday) Yrs.	If Under 1 Year	ST HILL If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 29,	Year) 9. E	of Death IARFORD 9. Birthplace (State or Foreign Country) New York				
any injury or other traumatic event, the involved a Examiner must be notified at once. To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Harford 10e. Street and Number 411 Cedar Spring Road 11. Marital Status 12. Was Decedent 14. Was Decedent 15. Was Decedent 16. Was Decedent 17. Was Decedent		1 Air 10f. Zip Code 2101			0g. Citizen of What USA 14. Race - A	10d. Inside City Limits 1 □ Yes 2X No Country? merican Indian,				
completed by Fur	Armed Forces? 1 Never Married 2 Married 32 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 9)	16a. Dece (Give life.	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes ※ INO Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker 14. Race - American In Black, White, etc. Specify: White 16b. Kind of Business/Industry White Own Home								
To Be C	17. Father's Name (First, Middle, Last) UNKNOWN		1	UNKNOW	N	Maiden Surname)					
0 0 0 0 0	19a. Informant's Name/Relationship (Type. Print) Richard S. Letts/Son 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo	Welby Dri sition (Name of matory or other place)	ve, Mid	lothian,	VA 23113 20c. Location - City	or Town, State				
once	4 Donation 5 Other (Specify) Hilltop Service Corp 8-28-07 Towson, Maryland 21. Signarye of Funeral Service Ucensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between interval Between										
edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undern in Cause (Disease or injury that initiated events c.	a consequence of): a consequence of): a consequence of):	emilia				Onset and Death				
Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown										
Completed by	Takin outer significant containing to death of	ut not resulting in the o	nachying cause given		1 ☐ Ye	es 2 No 3	Probably Unknown autopsy findings available to completion of cause of				
Medical Certification: To Be Completed by Physician/Med	25. Was case referred to medical examiner? 1 Yes 2 No	ıry 28b. Time o	ont 3 DOA Other: f 28c. Injury a Work? M 1 Ye	4 Nursing Ho at as 2 □ No	28d. Describe ho	ence 6 Other (S	pecify) Rural Route Number,				
Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	f examination and/or in	h occurred at the time vestigation, in my opin	, date and place, nion, death occur	, and due to the carred at the time, d	ause(s) and manner ate and place, and	as stated. due to the cause(s)				
V	29b. Signature and title of certifier		29c. License n			9d. Date signed (Me					
State		IAIL ROAD ar's Signature	Print) - BEL AIR	, MD. 2	21014						
gistrar v 1/2001	AUG 2 8 2007	OR OR	GINAL								

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event; the Medical Examiner must be notified at any Injury or other traumatic event; the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi

Division or Vital Records, P.O. Box 68760,

	1 - State Registrar			Certificate of Death						20	UI	2/505
	1. Decedent's Name (First, Middle, Las	st)						2. Date of De			V	3. Time of Death
an al	John L.	Lowe						August	Day 24	, 20	907 007	02:35 A ^M
er	4a. Facility Name (If not institution, give				4b. City, Town, c	r Location o	of Death		4c.	County	of Death	
	Morningside Assi	sted Livin	g	Glen Burnie						nne	Aruno	le1
	Social Security Number 6. S		e (In yrs. last b	irthday)	If Under 1 Year Months Days	If Under :	24 Hrs. Min.	8. Date of Bir (Month, Da	rth	(ear) 9. Birthplace (State or Foreign		
	212-05-4609	□ M 2□ F	94	Yrs.	Monard Bays	1100.0		Dec. 2		912		yĺand
	Usual Residence of Decedent 10a. State 10b. County		10c, City, Tox	wn or Lor	cation						1	0d. Inside City Limits
5	Maryland Anne Ar	undo1		rooklyn Park							'	1 ☐ Yes 2 ☐ No
ecto	10e. Street and Number	under	bro	окту	T				10- Cit	izon of l	What Cour	
ä												·
Funeral Director	5102 Kramme Av	12. Was Decedent	Ever in I.I.S	12 1/	21225	lienanio Oria	gin? /Sn	ooify Vos or N			State	
un-	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		13. 1	Vas Decedent of F Yes, specify Cub	an, Mexicar	n, Puerto	Rican, etc.)	J-		ck, White,	
by F	3 Widowed 4 □ Divorced	1 ⊟ Yes 2√1√1 If Yes, Give Year or Dates:	10	1	☐ Yes 2X No	Specify:				Specify	v: Wh	nite
ed	15. Decedent's Ed	lucation	16	a. Deced	ent's Usual Occup	oation			16b. K	ind of B	usiness/In	dustry
plet	(Specify only highest gra	ide completed) College (1-4or 5		(Give I life. E	kind of work done OO NOT use retire	during most d)	t of worki	ing	Ra 1 t	timo	re Ga	
E	1 2	2 College (1-40)	En	gine	er				Elec			15
Be Completed by	17. Father's Name (First, Middle, Last,	•				18. Mothe	r's Name	(First, Middle				
To E	William L.			Low	<i>i</i> e	Mart	ha K	och				
	19a. Informant's Name/Relationship (Type. Print)	19	b. Mailin	g Address (Street	and Numbe	er or Rura	al Route Numb	er, City o	or Town,	State, Zip	Code)
	Joan Carrick (da	aughter)	5	102	Kramme A	ve. B	rook	lyn Pai	rk, N	1D 2	1225	
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Domestal from State	20b. Place cemet	e of Disposition (Name of Date 20c. Locatery, crematory or other place)						c. Location - City or Town, State		
	4 ☐ Donation 5 ☐ Other (Specif		Glen	Have	en Mem. P	ark 8	-29-	2007	Gler	ı Bu	rnie.	Maryland
	21. Signature of Funeral Service Licer	isee]		/22 M.o.	Name and Addre	ss of Facilit	y I. F	norol I				
	FIRE C	Dur	Me	32	Cully-Po O4 Mount	ain R	oad	Pasader	na. N	$\sqrt{2}$	1122	
	23a. P. 1. Enter the disease, or com lock, or heart failure. List only	plications that caused one cause on each li	the death. Do	not ente	er the mode of dyi	ng, such as	cardiac o	or respiratory a	arrest,		THIS OLD	Approximate Interval Between
	Immediate Cause (Final disease or condition	ARI	nivat	ion		umo						Onset and Death
	resulting in death)	Due to (or as	a consequence	e of):		, υ						()
	Sequentially list southing		Inced	d Dementia								10 years
ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	ience of):								a
cam	that initiated events resulting in death) Last	· Page	chcor	on's Discare								
<u> </u>	Todaking in doutiny East	Due to (or as	a consequence									
Medical Examiner		_d										
/Me	IF FEMALE:	22a If you outcome	nf Prognancy						- 1			
ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal deal		Ectopic pregnanc	y					ite of delive onth	ery Day Year
ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant at 9⊡Unknown	time of death	5	Other (specify) _							
무	Part II. Other significant conditions of	ontributing to death b	ut not resulting	in the un	derlying cause giv	en in Part I.		23e. Did	tobacco i	use con	tribute to t	ne cause of death?
d b		-						1 🗆	Yes 2	No	3 ☐ Prob	oably 4 Unknown
ete								04- 14-	/	Lou	14/	- Cadina and Stabila
mp								24a. Was auto			prior to co death?	psy findings available impletion of cause of
රි	05.14					-		1□ Yes	2 No		1 ☐ Yes	2 No
Be	25. Was case referred to medical examiner? 1 Yes 2 Alo	Hospital:	-1 00000	N	Oth	er.		(Check only		Service .	Λε	rejeted
Ë	1 Yes 2 No	1 ☐ Inpatie		. Time of	3 DOA	_ 4 ⊔ Nu		me 5 Res 28d. Describe				sisted Living
ţi	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)	Injury	28c. Inju Woi M 1 □	rk? Yes 2∐I				.,		
fica	3 Suicide 6 Could not be	28e. Place of inju	ury - At home, f	farm, stre	eet, factory, office		28f. Location (Street and Number or Rural Route Number,					al Route Number,
erti	4 ☐ Homicide determined	building, et	c. (Specify)					City or To	wn, State	9)		
a C	29a. Certifier 1 Certifying Pr	ysician: To the best	of my knowledg	ge, death	occurred at the ti	me, date an	nd place,	and due to the	cause(s) and m	anner as s	tated.
Medical Certification: To Be Completed by Physician/	(Check only 2 Medical Examone)	niner: On the basis o and manner sta	f examination a ated.	and/or inv	estigation, in my	opinion, dea	ath occur	red at the time	, date an	d place,	and due t	o the cause(s)
Me	29b. Signature and title of certifier	1.	No		29c. Licens				29d. Da	te signe		Day, Year)
1 1 D 50470 8 84									4/80	007		

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WRI

2007

AUG 28

SRIDHAR 31. Date filed (Month, Day, Year) 810

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Minerva Ella Mulligan 21 2007 August /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bayview Mariner Health Care Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea April 21, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Year) 1 □ M 2 🛛 F 93 220-38-5175 Director 1914 Usual Residence of Decedent 10a. State 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 □ No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 313 Hospital Drive 21061 United States Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No þ 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) Be (18. Mother's Name (First, Middle, Maiden Surname) Jessie Bosley Schmidt Elsie Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Mulligan / grandson 60 C1 Glen Ridge Rd Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of 20a, Method of Disposition 20c. Location - City or Town, State Meadowridge Memorial Park 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 8/25/2007 Elkridge, Maryland 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signator of Funeral Service Litensee 1328 Sulphur Spring Rd Arbutus, Maryland 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (as a consequence of): resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 □ No 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records. P.O. Box 68760.

the death certificate be executed and burial-tran attending physician the as nse ned by the atter page 2 should certificate has funeral director, this e Hospital or Attending P 24 hours after death. e Funeral Director: After t etely filled in by the funera After within 24 hours at To the Funeral D

r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at

death

filed within 72 hours after

f Health and Mental Hygiene.

Department of Important: If it any Injury or o

Physician

Examiner

/Medical

Pages 1 and 2 should be nent of Health and Mental

3altimore, Maryland 21215-0036

State Registrar

Medical

EUNG 31. Date filed (Month, Day, Year)

AUG 2 8 2007

4 Homicide

(Check only

29b. Signature and title of certifier

29a. Certifier



29c. License number

1 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) □ay Month Year **Physician** Robert Moubrey, Sr. 13:20PM AUGUST 23 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SAINT AGNES HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth Aug. 31, Year) 943 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 216-42-1208 63 1 X M 2 □ F Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD n/a Baltimore 1 XYes 2 No 10e. Street and Number 516 S. Brunswick Street 10g. Citizen of What Country? U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Iten any injury or other traumatic event, th. Medi al Examiner once. Black White etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Phonix Company Material Handler 6 17. Father's Name (*First, Middle, Last*) Robert Huston Moubrey 18. Mother's Name (First, Middle, Maiden Surname) Angelina Mary Restivo 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 516 S. Brunswick St. Baltimore MD 21223 Katherine D. Moubrey/Wife 20b. Place of Disposition (Name of Crest Lawn Melloriaa)
Gardens
Gardens Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 8-28-2007 Marriottsville, Maryland 21. Signature of Funera Ambrose runeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus Md 21227 Service Licer see 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ALCOHLIC LIVER DISEASE MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Q I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ COHOLISM cate has been sig , page 2 should b 1 TYes 2 No 3 Probably 4 Nown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate l 1□ Yes 2 100 funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t 5 Pending investigation Natural To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one)

State Registrar

29b. Signature and title of certifier

Kohit Jain

ROHIT JAIN 31. Date filed (Month, Day, Year)

AUG 2 8 2007

MOUBRE

29c. License number

BALTIMORE

29d. Date signed (Month, Day, Year)

23

2007

AUGUST

and manner stated.

900 CATON AVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Helen Edna Morris 5 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BEL AND HEALTH If Under 24 H If Under 1 Year 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days 1 ☐ M 2 🗓 F 88 Director Jan. 25, 1919 Maryland 212-07-6755 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f shov Examiner must be notified at 1 X Yes 2 No Director Baltimore N/A Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Examiner must be m 21224 U. S. A. 7752 Wynbrook Road by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: 3 ₩idowed 4 Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laura Wilhelm ဥ Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7325 New Cut Road, Kingsville, Md. 21087 Victoria Sagal (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 08/29/2007 | Baltimore, Maryland Gardens of Faith 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home Inc. 9705 Belair Road, Nottingham, Maryland 21236 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Congestive disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? Kidney Disease 24a. Was an autopsy perform 2 No 1∏Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA AN Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Attending Physician: The law requires that the death certificate be executed Division or Vital Records,

sician and burial-transit attending physician the

the Maryland

Baltimore, Maryland 21215-0036

28a-f show

cate has been signed by page 2 should be detact in by the funeral

To the Hospital or Attending F within 24 hours after death.
To the Funeral Director; After

State Registrar

M

and manner stated

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) August 27, 2007

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Revolution St Benjamin Lee

Havre de Grace MD

31. Date filed (Month, Day, Year) AUG 2 8 2007

29b. Signature and title of certified

29a. Certifier

(Check only one)

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** annin PM Viorrisse August 25 *sosemary* 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hospita Johns Hopkins mor | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | November | 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Social Security Number **Funeral** 1□M **XX**F 080-30-3573 15,1935 | Scotland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Machinal Examiner must be notified at once. 10a, State 1 □Yes 2□No Director Maryland Baltimore Timonium 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21093 USA 2239 Chapel Valley Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Æ ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. þ Specify. 3 X Widowed 4 □ Divorced White Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hugh Canning Jane Keegan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Fairwood View Court Phoenix Maryland 21131 DTR Jane M Downs 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Lawn Cemetery 8/30/07 Shelton, Connecticut Donation 5 Other (Specify) signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 unis. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death 2 days Immediate Cause (Final disease or condition resulting in death) Hemorr hage **Physician**) ubgrachnow U /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leadin to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit Due to (or as a consequence of). the attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknowr signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably icate has been si , page 2 should b 1 Tes 2 No 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, certificate has this Hospital or Attending To the Hosping.
within 24 hours after death.
To the Funeral Director: Aft

physician

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 2

8

and manner stated.

104

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

apange

🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0062826

North Wolfe Street

29d. Date signed (Month, Day, Year)

Baltimore, MD 21287

25/0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 07 11:25 a^M Physician 24 08 Lawrence William Modlin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 X M 2 □ F 1917 North Carolina Sept 14, 89 163-05-9343 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a, State 1 ☐ Yes 2 No Director Laurel Prince George 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A 20707 6308 Julie Place Funeral 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White If Yes, Give Y Year or Dates: 1 ☐ Yes 2 ☒ No Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) U.S. Department of College (1-4or 5+) Elementary/Secondary (0-12) Agriculture Administrative Officer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna May Morgan James William Modlin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3415 Gregg Road, Brookeville, Maryland 20833 Linda M. Stefanowicz /daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State W. Arundel Crematory Aug 26, 07 Odenton, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 21. Signature Funeral Service Icens 313 Talbott Ave. Laurel, Maryland 20707-4389 M00773 Approximate Interval Between Onset and Death eath. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Metastatic Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit Due to (or as a consequence of): Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Vear in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 syndrome 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 TYes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 1 Inpatient 3□ DOA 1 ☐ Yes Certification: To 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide

Box 68760, P.0. Died 8/24/2007 Mod / in Division of Vital Records, P

Baltimore, Maryland 21215-0036

After this l or Attend after death. Director; / 24 hours a Hospital within 24 hou To the Fune completely fi

State Registrar

Medical

6 Could not be

4 Homicide

29b. Signature and title of certifier

29a. Certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D0036716 Quaust 24,2007

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kundrat, M.D 6/21 Montruse Rd, Rockville, Md 20852 31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mary Loftus Murphy AUGUST 23, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 20, 1 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 XF 017-09-2888 91 Director 1915 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore MD Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must boose. 207 Treherne Road 21093 USA Funeral Race - American Indian Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Loftus Susan Marley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Ellen Murphy/Daughter 207 Treherne Road Timonium, MD 21093 20b. Place of Disposition (Name of Artington National 20a. Method of Disposition Sept. 17, 20c. Location - City or Town, State 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 4 ☐ Donation 5 ☐ Other (Specify) Arlington, VA Cemetery 21. Signatur of Funeral Service Licensed
Bryan W. C. 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 clary 23a. Part1. Inter the disease, or complication, that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on sach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition resulting in the high) **Physician** SEPSIS /Medical Due to (or as a consequence of) Examiner ACUTE CHOLANGITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a q Unknown g
Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown HYPONATREMIA Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 2 No 24a. Was an RENAL FAILURE autopsy performed?

1 Yes 2 XNo certificate ha 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year) AUG 28 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

D65753

29d. Date signed (Month, Day, Year)

MARYLAND 21204

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Aug 21, **Physician** Frances Jean Moran 2007 7:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6201 Springhill Drive #201 Greenbelt Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 🙀 F 240 32 5505 78 Director Aug 21. 1929 North Caolina Usual Residence of Decedent the Maryland Pages 1 and 2 should be filed within 72 hours after deeth with the Marylannent of Heatth and Mental Hygiene.
ant: if item 27 is marked other then "netural", or iteme 23a or 28a-f ehow ury or other traumatic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Funeral Director Maryland Prince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6201 Springhill Drive #201 20770 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married A Married Baltimore, Maryland 21215-0036 1□ Yes 2□ No Specify: Completed by Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4th Housewife Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Emmett Richard Nellie Philyaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elbert M. Moran, Jr (Husband) 6201 Springhill Drive #201, Greenbelt, MD 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug 28, 2007 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Pages Depertment of Important: if it eny injury or o Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licens 70015 Alexandria Ferry Road, Clinton, MD 23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause or Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Dea Onset and Dea Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours efter death.

To the Funerel Director: After this certificate has been signed by the attending physicien and attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the at I be detached fo 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 Tyes 2 No. 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1 Yes 2 No : After this certificate funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending I Director: And in by the f investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 🔀 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AUG 33, 2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gabriel B. Jaffe, M.D. 7500 Hanover Pkwy #105, Greenbelt, MD 20817 31. Date filed (Month, Day, Year) 32 Registrar's Signature AUG 2 8 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Anne MOSKOWITZ **AUGUST** 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 □ F Director 129-26-6025 98 10/28/1908 CANADA Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD BALTIMORE OWINGS MILLS 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code If Item 27 is marked other than "natural", or items 23a or 2 or other traumatic event, the Medical Examiner must be n Funeral 3440 ASSOCIATED WAY #114 21117 U.S.A.

14. Race - American Indian,
Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify þ Specify: 3 V Widowed 4 □ Divorced 21215-003 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **HOMEMAKER** OWN HOME Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be VICTOR **ZUBER** PEARL GRUBER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If Item 27 is any injury or and HOWARD MOSKOWITZ / SON 2909 FALLSTAFF ROAD #22 - BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place)
MOUNT HEBRON Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/27/2007 FLUSHING, NY. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 15 Chem/c Cardimyonath /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 1 ☐ Yes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy performed? 1☐ Yes 2 X No Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) MSP W 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) emm

State Registrar

ころとに

DHMH 17 Rev 1/2001

6701 N. Charles St Towson no

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25 **Physician** 23:59 PM 200 Josefina Medina /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bay usedale If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, NOV . 17, 9. Birthplace (State or Foreign Country)
Puerto Rico 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Min. 1 ■ M 2 □ vF Nov. 73 115-28-3068 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Director Villa Carolina Carolina, Puerto Rico 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Calle 73 Blg 116 #25 00985 USA Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 □ Never Married 2 Married Maryland 21215-0036 Puerto Rican 1 X Yes 2 No Specify. \$ 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should b Health and Menta tem 27 is marked Felipe Medina Luz M. Pena 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20782 2801 Nicholson Street Apt. 304; Hyattsville, MD. Sonia Matos daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or 8/30/07 4 ☐ Donation ↑ 5 ☐ Other (Specify) La Resurrecion Carolina, Puerto Rico 22. Name and Address of Facility 21. Signature of Funeral Service Licensi 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician; The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown cate has been signed by i , page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1∐ Yes funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident hours after deat 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a Hospital 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ane) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) are Drive 9000 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend, item 11 per inf 9871 9-26-07 vt.
State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month 4:35PN AUGUST 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOPKINS HOSPITAL JOHNS BALTIMORE None CIT If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth June 3, 1933 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Pennsylvania 74 Yrs. 216-30-8813 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r 28a-f sh notified a 1 ☐ Yes 2 No Director Maryland | Baltimore Towson 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? pe o r Items 23a of their must be 1603 Essex Farm Road 21204 USA permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 may injury or other traumatic event, the Medical Examiner must once. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14 Wes 2 □ No Korea If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes XXNo Specify.White - Skillvidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+C01 Physician Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Antonio Peter Natale Josephine Cassano 2 19a. Informant's Name/Relationship (Type. Print)
Antonia Natale Schell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
782 Long Thorn Court Millersville, Maryland 21108 DTR 20a. Method of Disposition
1 ☐ Burial 2 ★ remation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State GreenMount Crematory | 8/28/07 Baltimore, Maryland □Donation 5 □ Other (Specify) signature of Funeral Service Licens 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIO VASCULAR COLLAPSE **Physician** 3 DAYS /Medical Due to (or as a consequence of): Examiner 3 DAYS HYPOTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ACUTE MYELDID YEARS LEUKEMIA the death certificate be executed the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as ed by the attending detached for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 2 No 3 Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 npatient ٥ 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death

1 Natural

2 Accident 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES -000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABRAHAM 600 North Wolfe Street BALTIMORE MD 21287 BISRAT

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

AUG 2 8 2007

32 Registrar's Signature

Joseph John Noz		For State	of Maryla	and / Depa	artment of		and	Menta	i Hyg) N-	20	17	2751
Physician/		<mark>egistrar</mark> . Decedent's Name (First, Middle,La	st)							Date of De		5 - 47	3. Ti	me of Death
Medical Examine		Joseph John No								Month August 2	6, 200	Year 7	0.	158 hrs
		a. Facility Name (if not institution, gi		umber)	4	b. City, Tov	vn, or Lo	ocation of				. County of De	ath	
		Baltimore/Washington Me	edical Cente	er		Glenn E	Burnie				Α	nne Arund	lel	
Funeral	5	. Social Security Number 6. S	Sex	7. Age (In yrs. la	ast birthday)	If Under		If Under	_	B. Date of B	irth(MM/	DD/YYYY) 9.	Birthplac reign	e (State or
Director		214-40-0635	M 2 F	67	Yrs	Months	Days	- Hours	Min.	11/8	/193	9	Country	Maryland
		Isual Residence of Decedent		07						11/0/	133.			
any	1	0a. State 10b. County		10c. City,	Town or Locati	on							1	Inside City Limits
and show	5	Maryland Baltim	ore	Ess	sex								1 _	Yes 2 X No
the Maryland a or 28a-f show tiffed at once	3 1	0e. Street and Number				10f. Zip Ci	ode				10g. Citi	zen of What C	ountry?	
Oiliging the	5	114 Sandhill Roa	d			2122	21				U.	S. A		
or items 23a or 28a-f sho	1	Marital Status	12. Was De	cedent Ever in U		s Decedent es, specify (of Hispa					14. Race - Ar White, etc		ndian, Black,
or ite	5	1 Never Married 2 XMarrie	1 Yes	2 X No					uerto Nic	sair, etc.)				
safter ral", o			d If Yes, Give Ye or Dates:		1_	Yes 2						Specify: W		
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imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or other tranmatic event, the Medical Examiner. To Be Completed by 1		John Edward No 9a. Informant's Name/Relationship (Z Type Print)		19h Mailine	Address		Eller			Whi	te lity or Town, S	tate Zin	Code)
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Balt Bermit. Depart Impor	1	1. Signature of Funeral Service Lice	rnsee //	_	Br	lame and Ad UZdzir	aski įski	Fune	eral	Home	PA			7 01 001
Physician	+	3a. Part I. Enter the disease, or com	polications that	cardsed the death	Do not enter t	07 Old	<u>d E.a.</u> dving. si	STETI uch as car	1 AVE	espiratory a	rrest, sh	OCK, or heart		nd 21221 proximate Interval
/Medical	ľ	failure. List only one cause on e	each line.				-, -, -,			,				etween Onset and Death
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). Box 68761 the death certificate by the attending phy ched for use as the the	٢	1 Yes 2 No 9 Unknow	9 Oliki							1				
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Division o spital or Attending hours after death. neral Director: After filled in by the fune Certification:		4 Homicide determin)						or Town	, State)			
Divisior Biospital or Attend 24 hours after death Funeral Director: stely filled in by the i		29a. Certifier 1 Certifying Physic	cian: To the be	est of my knowled	dge, death occu	rred at the ti	me, dat	e and plac	æ, and du	ue to the ca	iuse(s) a	nd manner as	stated.	
Division of Vital To the Hospital or Attending Physiciau: within 24 hours after death. To the Funeral Director: After this certificant completely filled in by the funeral director. Wedical Certification: To Be (<u> [</u>	one) 2 Medical Examin		of examination a										use(s)
F » F » E	<u>₹</u> 7	9b. Signature and title of certifier	_ 1			29c.	License	number			29d.	. Date signed	(Month, I	Day, Year)
		aliell	1/1				O.C.N	1.E.			Αυ	gust 27, 20)07	
01	H	30. Name and address of person wh	o completed car	see of death (Iter	n 23a)									
(x) y		Zabiullah Ali, M.D. Ass	sistant Medi	cal Examine	r 111 Per	n Street,	Baltir	more, M	ID 2120	01		_		
State	-	31. Date filed (Month, Day, Year) AUG 2 8 200	7	Registrar's Signat		N. A								<u> </u>
Registra		HUU & ● 200	· Ata	we ju	Apor									
DHMH 17 Rev 1/2001	1				ÖRIGINA	\L				M	ME			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner trawbridge erci 40 If Under 24 Hrs. 8. Date of Birth Month, Day, If Under 1 Year Birthplace (State or Foreign Country) last birthday) 5. Social Security Number 6. Sex 7. Age **Funeral** Days 1□ M 20 F Months Hours Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2/2 No a Director 10g. Citizen of What Country 10f. Zip Code 1128 Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 20 No If Yes, Give Race - American Indian Black, White, etc. 1 ☐ Never Married Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Korean 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1,-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JUN SOF MITTER

19a. Informant's Name/Relationship (Type. Print) (Grand Daus) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19a. Informant's Name/Relationship (Type. Print) (Grand Daus) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

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19a. Informant's Name/Relationship (Type. Print) (Grand Daus) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 29, Burial 2 ☐ Cremation 3 ☐ Removal from State Valley 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Funeral + Cremation Ct 21093 gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest each line. e, or complications that List only one cause on Immediate Cause (Final Physician ena nionti disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Jue to (or Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 ☐ Yes 2 | NO 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural thours after death.

-uneral Director: Ai
ely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manper stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed use of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

AUG 2

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2007

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32. Registrar's Signature

			State of Maryland / Department	artment of F			iene _{eg. No.} 2017	27518		
8	Physicia		Decedent's Name (First, Middle, Last) RUTH A. PROCHA	SKA		2. Date of Dea Month	Day Year	3. Time of Death		
)	/Medic Examin		4a. Facility Name (If not institution, give street and number)		r Location of Death	AUG. 2	7 , 2007 4c. County of Deat CARROLI			
	Funeral Director		MISTY RIDGE 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 285-18-2536 Yrs.		If Under 24 Hrs. 8	B. Date of Birth (Month, Day	9. Birt	hplace (State or Foreign untry)		
	Maryland a-f show ffied at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2X No		
	with the 3a or 28s t be not	Director	10e. Street and Number 2800 CARLISLE DR.	10f. Zip Code 21 7 7	6	1	Og. Citizen of What Co	ountry?		
036	of within 72 hours after death with the Maryland speed. Than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	Was Decedent of H If Yes, specify Cub	as Decedent of Hispanic Origin? (Specify Yes or Notes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 No Specify:			rican Indian, e, etc. ITE		
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212	filed within 72 Hygiene. other than "na ont, the Medic	Comp	Elementary/Secondary (0-12) College (1-4or 5+)	CI	LAIMS		SOCIAL SE	CURITY		
and	ntal ed c	To Be	17. Father's Name (First, Middle, Last) FRANK J. MORAVEC		18. Mother's Name (BLAHA			
Maryland	es 1 and 2 should of Health and Me item 27 is mark other traumation	-	, ,					City or Town, State, Zip Code)		
	s 1 and f Health item 27 other t		FRANK D. PROCHASKA -SON P.O. 20a. Method of Disposition 20b. Place of Disposition cemetery, cree	ī	MD 21776 Dc. Location - City or Town, State					
Baltimore,	permit. Pages Department of Important: If it any injury or o once.		(4□Donation 5 ☑Other (Specify) Entombment LOUDO 21. lign view Fun → Service Licensee	RALTIMORE FUNERAL INSTER, M	HOME, P.A.					
	Physician /Medical Examiner		23a. Part1 Enter the disease, or complications that caused the death. Do not en shoct, or he it failure. List only one cause on each line. Immediate vaus (Final disease or circli tition resulting in death) a. Due to (or as a consequence of):	nter the mode of dyi	ng, such as cardiac or	respiratory and	rest,	Approximate Interval Between Onset and Death		
	ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Cu. Due to (or as a consequence of):							
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ds, P	signed by	Š	Part II. Other significant conditions contributing to death but not resulting in the to	underlying cause gi	ven in Part I.		obacco use contribute t ′es 2 No 3 P	/		
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	tal or Attenders after death al Director: led in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	Street and Number or Fi vn, State)	lural Route Number,					
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or i and mariner stated.	ath occurred at the investigation, in my	time, date and place, a opinion, death occurre	nd due to the ed at the time,	cause(s) and manner a date and place, and du	s stated. le to the cause(s)		
}	To the within the complete of	Ň	29b. Signature and title of certifier		se number		29d. Date signed (Mon	th, Day, Year)		
	12		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print) Pool	e FD U	ubotin	unstee n	21157		

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** August 10:15 PM 24,2007 Edward Phelps Charles /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RCI Point System rerry Health Care VAMaryland 5. Social Security Number 7. Age (In yls. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 1 X M 2 □ F 220-05-0183 86 DEC 10 1920 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 □Yes 2X No Director MD Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8123 Foxwell Road 21108 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No
If Yes, Give
Year or Dates: 39-45 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ Specify: 3 ☐ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accountant Unk. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Frances H. Phelps Margaret Barnitz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other tra Lynne Adams - niece 195 Woodland Road, Tryon, NC 28782 Baltimore, 734 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 X Cremation 3 ☐Removal from State Metro Crematory, Inc. 8/28/2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Steeven H. Williams Cremation Society of Maryland, 299 Frederick Road, Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer **Physician** olon UNKNOWN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 1 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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State Registr<u>ar</u> Sures

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DHMH 17 Rev 1/2001

VAMaryland Health Care S

roint, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shandel

2/Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 5:00 PM 2007 PERUN AUGUST PAULINE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner S, WASHINGTON 57, BALTIMOR If Under 1 Year | If Under 2 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 ☐ M 2 🕱 F 215-34-7753 Usual Residence of Decedent CCT. 17, 1922 UKRAIN Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County at 1 XYes 2 No 28a-f sh notified BALTIMORE Directo MARYLAND 10g. Citizen of What Country? 10e. Street and Number or be r U.S. A. ral", or items 23a Examiner must b 212 Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No WHITE 3 Widowed 4 □ Divorced "natural" er than "natura the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SEAMSTRESS GARMENT item 27 is marked other other traumatic event, tl 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WERLEYS CORNER RD. NEW TRIPOLI, PA, 18066 JOSEPH 20a. Method of Disposition permit. Pages ' Department of H Important: If it any injury or o once. 1 D Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ST. MICHAEL CEMETERY AUG 25 LOOP BALTIMORE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of acility LILLY + ZEILER, INC. FUNERAL HOMES 1901 EASTERN AVE, BALTIMORE MD. JIJJY 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cadse on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner 8 tan nota Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Due to (or as a consequence of): physician a Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Vear 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗆 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 📝 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes Certification: To this 27. Manner of Ceath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Injury 1 Natural Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 5 Director: / Vithin 24 hours are.

To the Funeral Dir

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State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30 Mame and address of person who completed cause of death (Item 23a) (Type, Print)

20

31. Date filed (Month, Day, Year) AUG 2 8 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 21 7 ZDD7 **Physician** ugn87 Hobert Ε. Phillips /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Jhr 4 Baltimore-Washington Medical Center If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 ☐ F 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Days Hours 213-32-7439 69 Dec. 4, Director 1937 West Virginia Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location Hygiene. other than "natural" or items 23a or 28a-f show ent, the Medical Examiner must be notified at 10a. State 1 ☐ Yes 2 No Director Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1749 Marley Avenue 21060 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) N/A Bethlehem Steel Corp Leverman Department of Health and Mental Hygiv Important: If item 27 is marked other any Injury or other traumatic event, it once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Bright <u>Cyrus</u> Phillips 4 8 1 <u>Minnie</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William E. Phillips (Son) 1749 Marley Avenue Glen Burnie, Maryland 21060 of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 08/23/07 Baltimore. Maryland 2 Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Funeral Service Licensee 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sbock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cance Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 🗆 No 3 y robably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy performed? To the Hospital or Attending Physician: after death.

Director: After this certification in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ∰Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Txpe, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 25, 2007 Year **Physician** Kenneth Louis Quinter 1:00 Ам /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 1333 Southwell Lane Be1 Air Harford 6. Sex 1 M M 2 □ F If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Birthplace (State or Foreign Country) Months Days Hours Director 216-28-9007 73 22, 1933 Nov. Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1333 Southwell Lane 21014 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No white Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Warren Lester Quinter ၉ Beatrice Ethel Baranyi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Stephen Quinter 75 Roop Road; Rising Sun, MD 21911 brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 8/29/07 4 Donation 5 Dother (Specify) Moreland Mem. Park Parkville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 York Road un Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic Obstructive Pulmonary Disease ten years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dualto (or as a nonsequence of) or Attending Physician: The law requires that the death certificate be executed the burial-transit Division or Vital Records, P.O. Box 68760, 🕏 Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Lung Cancer 1 X Yes 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 은 1 ☐ Yes 2 ☐X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred Certification: 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a To the Funerai To the Hospital 1 🖔 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of 29d. Date signed (Month, Day, Year) D0056296 8/27/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12

Registrar DHMH 17 Rev 1/2001 Jason M. Birnbaum, M.D.

AUG

31. Date filed (Month, Day, Year)

32. Registrar's Signature

520 Upper Chesapeake Drive; Bel Air, MD 21014

		For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Mar		-	tificate c				eg. No. 2	007	2 1 5 2 3. Time of Death	
Physicia /Medic	_	1. Decount of table (1. New Manual)	Frank	Geor	ge Ri	ce, Jr			Augus	⊢ "ঠৈ	2007	11:50	
Examin		4a. Facility Name (If not institution, give si				4b. City, Tow		n of Death	•		nty of Death		
	H .	Laurel Regional H 5. Social Security Number 6. Sex		(In yrs. last	birthday)	Laure		er 24 Hrs.	8. Date of Birth		ce Geo	ace (State or Forei	
Funeral Director			M 2□F 8:		Yrs.	Months Da	ys Hours	Min.	(Month, Day Dec 9,	1923	Maryl	ry)	
filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	<u>.</u>	10a. State 10b. County		10c. City, T	own or Loc	cation					10	od. Inside City Limit	
ne Ma 8a-f s otifie	Director	MD Prince Ge	orge	Laure	el	104 7in Cos			1	10a Citizen	of What Count		
or 2 be no		10e. Street and Number				10f. Zip Coo						.у.	
s 236	eral	602 Talbott Avenu	2. Was Decedent Ev	ver in U.S.	13. V	2070		Origin? (Spe	cify Yes or No-	U.S.A.	Race - America	an Indian,	
be lifed whith 7.2 mous aren dearn with the manyar hall Highene. Hot other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2X Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:			fYes, specify (☐Yes 2【X			cify Yes or No- Rican, etc.)		Black, White, $\epsilon^{cify:}$ Wh i t		
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riled within Hygiene. other than " ent, the Mec	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	•)	life. I Carpe		tired)			Const	nstruction		
0 2	Be C	17. Father's Name (First, Middle, Last)					18. Mo	ther's Name	(First, Middle, Maiden Surname)				
and Mental I	To E	Frank George Rice	, Sr.				Ma	ude A	gnes Lei	es Leman			
and N s ma		19a. Informant's Name/Relationship (Typ	e. Print)		19b. Mailin	g Address (Str	eet and Nun	nber or Rura	al Route Numbe	er, City or To	wn, State, Zip	Code)	
n 27 i		Josephine M. Rice	/spouse								and 20707		
or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	20b. Plac	e of Dispo letery, cren	sition (Name o natory or other	place)		Date		on - City or To		
ment ant: ury c		4 □ Donation 5 □ Other (Specify)		W. A		el Crem		_			on, Mar	yland	
Department of Health and Mental Important: If item 27 is marked any Injury or other traumatic events.		21. Signatur of Funeral Strice License 22. Name and Address of Facility Donaldson Funeral Home, P.A. M00773 313 Talbott Ave. Laurel, Maryland 20									nd 207	07-4389	
		23a. Part1. Enter the disease, or complications shock, or heart failure. List only on	cations that caused t	the death.	Do not ent	er the mode of	dying, such	as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death	
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/Medical		resulting in death)	Due to (or as a	consequer	nce of):								
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sit s	ine	Sequentially list conditions, Locause. Enter Underlying Cause (Disease or injury Chronic Renal Failure								V	ears		
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w requires and been signed I should be det	ed by								1 🗆 '	Yes 2□N	lo 3□ Prob	ably 4 ⊠Unkn	
	Completed by								24a. Was autop perfo 1∐ Yes	osy rmed?	4b. Were auto prior to cor death? 1 ☐ Yes	psy findings avail mpletion of cause 2 No	
this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital: , 🔀 ,				Other:		h (Check only o				
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within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best oner: On the basis of and manner state	examinatio	edge, deat n and/or in	h occurred at to	he time, date my opinion,	e and place, death occur	and due to the red at the time,	cause(s) an date and pla	d manner as s ace, and due to	tated. the cause(s)	
within To the	Me	29b. Signature and title of certifier	7/1/2	1104		290	cense numb	210	2	29d. Date s	igned (Month,	Day, Year)	
141		30. Name and address of person who co					. 0	,		ارسدا	W 1 0	1000	
)		William A. Warren	, M.D. 3	21 Pr	ince		Stree	t, La	urel, Ma	arylan	d 2070	7	
St	ate	31. Date filed (Month, Day, Year)	A92. Registra	ar's Signatu	re Ana	13							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Of Maryland / Department of Heart State Certificate of Dea		Reg. 1	-2067	27524								
	Dhusisis		1. Decedent's Name (First, Middle, Last)		ate of Death onth	Day Year	3. Time of Death								
	Physicia /Medic		ERIC ROBERT RICHMOND, JR.		GUST	24 2007	11:20 P M								
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locati	tion of Death		4c. County of Death									
			Greater Laurel Health & Rehab. Laurel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Un	nder 24 Hrs. 8, Da	ate of Birth	Prince Ge	orge's place (State or Foreign								
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	land ow		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits								
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	h the	Director	10e. Street and Number 10f. Zip Code		10g.	Citizen of What Cou	ntry?								
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	r dea tems er mi	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic If Yes, specify Cuban, Mexical Status	S. 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			can Indian, , etc.								
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ary	s 1 and 2 should be 1 Health and Mental I tem 27 Is marked of other traumatic eve	-	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and No.	lumber or Rural Rou	ite Number, Cit	ty or Town, State, Zi	p Code)								
	5 = 2 -		Eric Rynn/ Son 1452 Windsong Co	ourt, Mas	son, Oh	io 45040									
J. C.	ges 1 ar t of Hea if Item 3 or other		20a. Method of Disposition 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c	. Location - City or T	own, State								
<u>Ĕ</u>	permit. Pages 1 Department of H Important: If Ite any Injury or ot	- 3	4□Donation 5□Other(Specify) West Arundel Crem.	8/28/20	1	enton, MD									
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			shock, or heart failure. List only one cause on each line.												
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Вох	eath certif attending for use a	ian/	23b. Was decedent pregnant in the past 12 months?			23d. Date of deli- Month	very Day Year								
	The law requires that the death cer ate has been signed by the attendin bage 2 should be detached for use	Physician/M	1 Yes 2 No 9 Unknown												
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or Vital Records,	aw require s been si	Completed	Gero	2	24a. Was an	24b. Were au	topsy findings available ompletion of cause of								
Re	hysiclan: The lav his certificate has I director, page 2 s	omp	Stroke		autopsy performed 1∐ Yes 2. ☑	death?	My No								
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<u>r</u> V	Physiclan: this certific	To	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X			e 6 □Other (Spec	eify)								
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Division	al or Ai after o I Direct d in by	Certification:	4 Homicide determined determined building, etc. (Specify)		City or Town, S		Tarriodic Hambon,								
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, day one best of my knowledge, death occurred at the time, day one best of my knowledge, death occurred at the time, day one best of my knowledge, death occurred at the time, day one best of my knowledge, death occurred at the time, day one best of my knowledge, death occurred at the time, day one best of my knowledge, death occurred at the time, day one best of my knowledge, death occurred at the time, day one best of my knowledge, death occurred at the time, day one best of my knowledge, death occurred at the time, day one best of my knowledge, death occurred at the time, day one best of my knowledge, death occurred at the time, day one best of my knowledge, death occurred at the time, day one best of my knowledge, death occurred at the time, day one best of my knowledge, death occurred at the time, day one best of my knowledge, death occurred at the time, day one best of my knowledge, death occurred at the time, day one best of my knowledge, death occurred at the time, day one best of my knowledge, death occurred at the time, day one best of my knowledge, death occurred at the time, day of the best of my knowledge, death occurred at the time, day of the best of my knowledge, death occurred at the time, day of the best of my knowledge, death occurred at the time, day of the best of my knowledge, death occurred at the time, day of the best of my knowledge, death occurred at the time, day of the best of my knowledge, death occurred at the time, day of the best of my knowledge, death occurred at the time, day of the best of my knowledge, death occurred at the time, day of the best of my knowledge, death occurred at the time, day of the best of my knowledge, death occurred at the best of my knowledge, death occurred at the time, day of the best of my knowledge, death occurred at the best of my knowledge, death occurred at the best of my knowledge, death occurred at the best of my knowledge, death occu	ate and place, and on the same of the same	due to the caus t the time, date	e(s) and manner as and place, and due	stated. to the cause(s)								
	To the To the To the Comp.	Me	29b. Signature and title of certifier 29c. License num	nber	29d.	Date signed (Month	n, Day, Year)								
			lamplee 005323	35	Au	gust 27,	2007								
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)												
)		Darryl Hill, 13635 Baltimore Avenue, Laure	el, MD 2	0707										
*	Sta Regist		31. Date filed (Month, Day, Year) AUG 2 8 2007												
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 03:41 PM ROTHERMEL HAZEL 20 2007 Auc 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE HARBOR HOSPITAL N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 9, 1926 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 1 □ M 2 1 T F 214 22 0256 81 Yrs Virginia Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 € Yes 2 No N/A Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1246 Hull Street 21230 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coflege (1-4or 5+) Hess Shoe Store Dved Shoes 6th 18. Mother's Name (First, Middle, Maiden Sumame) UNKNOWN 17. Father's Name (First, Middle, Last) Owen Burdett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 341 Grove Park Road Baltimore, Maryland 21225 Virginia Gordan / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Craigsville Community $8/24/_{07}$ Craigsville, Virginia 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses monuscrifte 4001 Ritchie Highway Baltimore, Maryland 21225 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Immediate Cause (Final PULMONARY EDEMA disease or condition resulting in death) Due to (or as a consequence of) 6 DAYS CHF EXACERBATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) UNKNOWN END-STAGE COPD that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. TRACT INFECTION WRINARY 1 Yes 2 No 3 Probably 4 Unknown FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? ATRIAL 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work? Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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Pages 1 and 2 should be filed within 72 hours after in and of Heelih and Mertal Hygiene.

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Baltimore, Maryland 21215-0036

Box 68760.

Division of Vital Records, P.O.

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Director

Completed by Funeral

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Examiner Physician/Medical \$ Completed Certification:

29a. Certifier Medical

ettending physicien and for use as the burial-transit The law requires that the death certificate be executed the To the Hospital or Attending Physician: within 24 hours effer death.
To the Funeral Director: After this certifice completely filled in by the funeral director.

ADEKUNLE 31. Date filed (Menth, Ray, Year) AUG 2 8 2007 State Registrar

1 ANatural

2 Accident

3 🗌 Suicide

4 Homicide

(Check only one)

29b. Signature and tyle of

5 Pending

investigation

6 Could not be determined

KICCCOLL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARBOR HOSPITAL, 3001 S. HANDER ST., OBISESAN, MD

32 Registrar's Signature Gode

MD.

CRIGINAL

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number RES000

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Certifying Physician: To the best of hig knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Auce 2007

MD 21225 BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Roland L. Rexroth 440 August 21 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore N/A Union Memorial Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** XXM 2□F Months Days Hours 90 Yrs. 213-03-7555 Director June 14, 1917 Maryland Usual Residence of Decedent the Maryland 10c. City. Town or Location 10b. County 10d. Inside City Limits 28a-f show must be notified 1XXes 2∏No N/A Director Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with ō 277 West 31st Street 21211 USA Items 23a Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XXes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎞 No Specify: white Specify: ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic MTA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Rexroth Marie မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i other tra Gaynelle Wilson (Friend) 15 Locust Path Court Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Lake View Memorial Pk 8/25/07 Sykesville, Maryland 4 Donation 5 ☐ Other (Specify) Funeral Service Lice 22 Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 21. Signal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or complications) Approximate Interval Between Onset and Death Physician 9 days Due to (or as a consequence of): resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Yea 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Atrial Fibrillation 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 1□ Yes 2☑No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပို 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No s after death.

I Director; A

id in by the fu 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined within 24 hours aft To the Funeral DI completely filled in 1 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Me.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

memorial Hospital, MD

29d. Date signed (Month, Day, Year) August 22, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** August 200 Dorothy Schlesinger /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE GLEN BURNIE BACTIMORE WASHINGTON MEDICAL GRIVER ARUMDE if Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Manths | Days | Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Year) 1 M 2 July 14, 1911 Arkansas 432-05-3482 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2√ No MD Anne Arundel Pasadena 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21122 752 216th Street USA death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: white Completed by 3 Widowed 4 □ Divorced Year or Dates: "natural", 16a. Decedent's Usual Occupation 77 is marked other than "natu traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 housewife own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Whitney Pearl Newlon ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai once. Dottie Grady/daughter 752 216th Street Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signa in of cuneral Service Licensee Ronald S. Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 2∏ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate ha 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 2 1 ☐ Yes 1 inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mann of Death funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the I

> State Registrar

Medical

29a. Certifier

(Check only one) 29b. Signature

title of certifie

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d cause of death (Item 23a) (Type, Print)

201 32 Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D 45149

Hospital Drive, Elen Burne mi) 20161

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 08 Day Year **Physician** 7:05 AM 22 2007 Robert William Shipley /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore were Hospital Center Koredala tranklin If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**∑**M 2□F Yrs. 78 Feb. 27, 1929 Maryland Director 214-24-0381 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location or iteme 23a or 28e-f ehow or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 21 No Director Maryland **Baltimore** Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21236 U. S. A. 4502 Fieldgreen Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Automotive Elementary/Secondary (0-12) College (1-4or 5+) Machine Shop President 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any linty or other traumatic event 2008. 17. Father's Name (First, Middle, Last) Ruth Steward Raymond Shipley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4502 Field reen Road, Baltimore, Maryland 21236 Flornel M. Shipley (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 108/25/2007 Baltimore, Maryland Parkwood Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. 9705 Belair Road, Nottingham, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Chastrointestinal /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical attending physical for use as the t 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the at the detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Medical Certification; To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20058371 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) quare Drive 21237 Baltimore maryland Dr. Mya Sanda 9000 Franklin S Thein 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar

AUG 2 8 2007

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 25, 2007 4:45 P August Josephine Mary Szech /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Parkville Baltimore 0akcrest If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 15, 1 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 😾 F Yrs. 1921 Maryland 85 Nov. 220-09-6397 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 21 No Director Parkville Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U. S. A. 21234 8820 Walther Blvd., Apt 4323 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify Specify. 2 White 3 ☑ Widowed 4 ☐ Divorced "natural" Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) other than Homemaker Own Home 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked Rose Raul Harrison M. Boston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 1005 Goose Cross Ct., Bel Air, Maryland 21014 Barbara Young (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Bemoval from State 4□Donation 5 MOther (Specify)Maulsoleum Holly Hill Mem. Gdns. 08/29/2007 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licensee 9705 Belair Road, Nottingham, Maryland 21236 ولل Les 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) bonastive Physician /Medical Due to (or as a conse wince of): Examiner valvula if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Hinknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performe certificate 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Medical Certification: To this (27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 6 Hospital within 24 hours a

To the Funeral i

completely filled t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) vest 31. Date filed (Month, Day, Year) egistrar's signature State AUG28 Registrar 2007

		For 1 _ State	State of Maryland		rtment of Health		ntal Hygie	2007	27530
		Registrar 1. Decedent's Name (First, Middle, Las	*1	001	incate of Death		Date of Death	No. O O	3. Time of Death
Physi	ician	Wanda J.	Smigovsky				Month 2	Day Year	1:01AM
/Med Exam		4a. Facility Name (If not institution, give			4b. City, Town, or Location	of Death	0	4c. County of Deat	
LAdii	illiei	· · ·	gland Medical	Ctv.	Baltomore			N/A	
Funera	al	5. Social Security Number 6. Se	DAY OFFICE		If Under 1 Year If Under Months Days Hours	Min.	Date of Birth (Month, Day, Yo	9. Birtl	nplace (State or Foreign untry)
Directo	r	216-24-4148 Usual Residence of Decedent	/	9 Yrs.		INC	ov. 11	1927	WV
rland ow		10a. State 10b. County	10c. City,	Town or Loc	cation				10d. Inside City Limits
Man P-1 sh	tor	Maryland Anne A	\rundel		Pasad	ena			1 ☐ Yes 2 ☑ No
iff the	Oire	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	untry?
il Z i 3-0030 within 72 hours after death with the Maryland ene than "natural; or items 23e or 28e-f show than Madical Examiner must be notified at	Funeral Directo	711 Birch Avenue	10.111 - Day 1-2 E-2 in 11.6	140.1	2112		. Ves or No-	USA 14. Race - Ame	ocan Indian
items	in ne	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No	13. V	Vas Decedent of Hispanic O Yes, specify Cuban, Mexica	an, Puerto Ric	an, etc.)	Black, White	e, etc.
hours af	2	3 ☐Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	Yes 2 No Specify	y:		Specify: W	hite
72 ho	Completed	15. Decedent's Ed (Specify only highest gra		(Give	lent's Usual Occupation kind of work done during mo	est of working	16	b. Kind of Business/	Industry
ithin and and and and and and and and and an	aldu	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. [OO NOT use retired)		0	ocial Soc	urity Admin.
iled w tygier therti				Sy	stems Operato		irst, Middle, Ma		urity Admin.
d be fill antal High	Be	Milliam Dl	air		Dar	lene	St	yles	
D Out	٩	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailin	g Address (Street and Numi	ber or Rural R	oute Number, C	city or Town, State, Z	Zip Code)
and 2 s alth an 127 is		George L. Smigovsk	ky III (son)	2544	Holly Spring	100000			
Daillinore, permit. Pages 1 an Depertment of Heal important: if Item 2 any injury or other		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □	CO	ace of Dispo metery, cren	sition (Name of natory or other place)	August	29 20	c. Location - City or	Town, State
Pag ment ant: i		4 □Donation 5 □ Other (Specify	, Ced		🛘 Cemetery 🖠	2007	B	altimore,	
ermit.	e de	21. Signature of Funeral Service Licen	see	22	. Name and Address of Fac				Home, P.A.
40.50	d	23a. Part 1. Enter the disease, or com	dications that caused the death	Do not ent	3111 Mountai				Approximate
		shock, or heart failure. List only	one cause on each line.		, , , , , , , , , , , , , , , , , , , ,				Interval Between Onset and Death
Physicia: /Medica		disease or condition resulting in death)	a. Hypotensi						
Examine			Seosis						
	Je Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):					
ocuted transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
ate be executed by sicien and the burial-transit			Due to (or as a conseque	ence or,					
68 / 6U ificate be a physicient street buri	dical	`	d						
COTGS, P.O. BOX 68/ requires that the death certificate been signed by the ettending phys should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan		Ectopic pregnancy			23d. Date of de	
death death	icia	in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of deal of the second		Other (specify)			Month	Day Year
ecords, F.O. law requires that the es been signed by th 2 should be detache	Phys	9 Unknown		N' 1- At	da bia a sa sa sa Sas		22e Did toba	cco use contribute to	the cause of death?
IS,	۾	Partition of Significant Contactions	onthouting to death but not resul	iting in the ur	nderlying cause given in Fai	· i.			obably 4 Yunknown
ecords, law requires t es been signe 2 should be	Completed						24a. Was an	24h Were au	utoosy findinos available
e lay		-					autopsy performe	d? death?	utopsy findings available completion of cause of
VITAL P ilcian: Th certificate rector, pag	100	25. Was case referred to medical			26. Pla	ce of Death (0	1 ☐ Yes 2 ☐ Check only one)	NO IL TOS	2 140
_ \$ <u>\$</u>	ToB		Hospital: 1 Inpatient 2 E	ER/Outpatien	t 3 DOA Other: 4	Nursing Home	5 🗆 Residen	ce 6 ☐Other (Spe	cify)
On Or ding Phy h. After this funeral d	2	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work?		d. Describe how	injury occurred	
JIVISION I or Attending after death. Director: After	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		ma form at	M 1 Yes 2		Location (Stre	et and Number or R	ural Route Number.
DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun	Certification:	4 ☐ Homicide determined	building, etc. (Specify))	eet, factory, office	120.	City or Town,	State)	
spita nours nerai	2		ysician: To the best of my know	vledge, deatl	occurred at the time, date	and place, and	d due to the cau	se(s) and manner a	s stated.
he Ho n 24 l he Fu	edical	(Check only 2 Medical Exam	niner: On the basis of examinati and manner stated.	ion and/or in					
To t To t	Σ	29b. Signature and title of certifier			29c. License numbe		290	d. Date signed (Mont	n, Day, Year)
		33			752	.7		8/24/0+	
Ь		30. Name and address of person who Tevesa Niemiec				one M	D 71	201	
	State	31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure	31., Jan 1100				
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Security Here (First Institution of Death Security Here (First Institution of Death Institut				For State Registrar	State of Ma	lyland		itment of tificate of			lental Hy	giene Reg. No. 🤈	007	27531
Control Part Cont						LE SC	HAEFE	R			Month	_	00 7	3. Time of Death 11:48 A M
Column C					· ·								,	
Source Street Source S					Sex 1 □ M 2 K F 7. Age						8. Date of Bi	^{rth} , Yazzi 18		
County of the control of the county of the c		ne Maryland 8a-f show biffed at	ector	10a. State 10b. County Maryland Baltimo	-	10c. City, T		inoniun						10d. Inside City Limits 1
Counting of the control of the counting of the		th with the 23a or 2 st be no	al Dire	200								10g. Citizen o		ntry?
County of the control of the county of the c	•■•	urs after dea al", or items Examiner m	by	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give			_			ecify Yes or No Rican, etc.)		ack, White,	etc.
Counting of the control of the counting of the	:48 a, 21215-0	within 72 ho liene. r than "natur the Medica I	ompleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) School Administrator							ing			
Sankica 3. (upp Court of the part of the		be d all all eve	Be	, ,	,	chardi	t		18. Mol	_			,	
Approximate of June 1 Appr		ロサビサ		· ·				•						
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Physician Medical Examiner Physician Medical Examiner Physician Medical Examiner Physician Medical Examiner Physician Medical Examiner Physician Physician Physician Medical Examiner Physician Phy	UGUS Balt	permit. Departr Importa any inju			1 MARION	Xau	5m 189	i verse 17º 500 York	Wiede Roas	feld I. Ba	Funera ltimore	1 Hone, Maryl	Inc.	:1212
FEMALE: 23b. Was deedednt pregnant in the past 12 months? 1	87605	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. Due to (or as a consequence of): Due to (or as a consequence of):										Onset and Death
Cheek only one Chee	Box 6		ysician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 📉 No	1 ☐ Live birth 2 4 ☐ Pregnant at t	eath 3								
24a. Was an autopsy prindings available prior to completed or death? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 28. Describe how injury occurred 28.	ds, P	juires that n signed by Id be deta	þ	Part II. Other significant conditions	contributing to death but									
The state of the s	EDA SU	The law ate has b page 2 st	Complete	autopsy performed?									24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No	
State State		yslclan is certifi director	o Be	examiner?	Hospital' Other									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 State 31. Date filed (Month, Day, Year) 3 Registrar's Signature		Attending Ph r death. ector: After th by the funeral		C7 Manager of Double										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 State 31. Date filed (Month, Day, Year) 38 Registrar's Signature	۵	spital or ours afte neral Dir filled in					edge, death	occurred at the	time, date	and place,			manner as	stated.
DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	_	To the Hos within 24 h To the Fur completely	Medica	one)	aminer: On the basis of and manner stat	examination ed.	n and/or inv				rred at the time			
State 31. Date filed (Month, Day, Year) 3 Registrar's Signature		13				·	, , , ,		14:	5/2	-5	8	1281	0/
Registrar AUG 2 8 2007		~			32 Registra		е		TIMON	IUM,	MD 2109	93		

			For State Registrar	State of	Maryland	-	artment <i>rtificate</i>				-	giene,	07	275	32		
	Physic	an	1. Decedent's Name (First, Midd.	(e, Last)			< n	117	7+		2. Date of De. Month	Day	Year 2007	3. Time of			
	/Medi Exami	10.0	4a. Facility Name (If not institution	n, give street and numb	per)		4b. City. 1	Town, or	Location of	of Death	00	4c. Coun	ty of Death	1000			
Ā	LAGIIII	W.	3107 River Ber	. •	,		Lauı						Aruno	io.			
	Funeral		5. Social Security Number	6. Sex 7.	. Age (In yrs. last	birthday)	If Under	1 Year_	If Under		8. Date of Birt	h		lace (State or etry)	r Foreign		
ry	Director		068-64-8550	1□M 21 F	58	Yrs.	Months	Days	Hours	Min.	(Month, Da NOV 1	1948		n Carol			
	pu ,		Usual Residence of Decedent 10a, State 10b, County		10. 01. 7												
	ehov	7	,		10c. City, T		ocation						1	0d. Inside Cit			
	he M	Director	SC Kers 10e. Street and Number	haw	Cam	den	1.00					10 011					
	ours after death with the Maryland ei', or items 23a or 28a-f ehow Ezartifrat must be politied at			L L			10f. Zip		00000			10g. Citizen of		try?			
	eath	Funerai	607 Market S	12. Was Deced	ent Ever in U.S.	13	Was Docade		29020		ofu Voe or No		SA Ice - Americ	an Indian			
	fter d	Fun	1 Never Married 2 XMar	Armed Forc	es?				n, Mexican	n, Puerto F	cify Yes or No- Rican, etc.)	BI	ack, White,				
936	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Voe Cino			1 ☐ Yes 2	Ĭ¥No	Specify:			Spec	ify: Blac	:k			
Õ		Completed		it's Education	1	6a. Dece	dent's Usual	Occupa	tion			16b. Kind of	Business/Inc	dustry			
21	within 7 ene. then "r h Med	βidu	Elementary/Secondary (0-12)	st grade completed) College (1-4	or 5+)	life.	kind of work DO NOT use	e retired)	uring mosi	t or workir	ng						
21	filed wi Hygien Ither th	Son	12th	Ø		N	urse					Healt	h Care	e Facil	lity		
Maryland 21215-0036	ges 1 and 2 should be filed within 72 ho t of Health and Mental Hygiene. If Item 27 is marked other then "nature or other treumatic event, the Mudical	Be (17. Father's Name (First, Middle,						18. Mothe	er's Name	(First, Middle,	Maiden Suma	me)				
yla	should ind Meni	ဥ	Marrow Bradf	ord					I	ouis	e Chamb	ers r, City or Town, State, Zip Code)					
Mar	2 sh and ie m		19a. Informant's Name/Relations	hip (Type, Print)									n, State, Zip	Code)			
	and lealth m 27		Pamela Prince/	Daughter	Tax at				nd Co		Laurel		20724				
9	ges 1 t of H if ite or otl		20a. Method of Disposition 1 Burial 2 Cremation	3√□Removal from St		of Dispositery, crei	natory or oti	e of her place)	D	ate	20c. Location	- City or To	wn, State			
Ë	mit. Pagartmen cortant: injury		4 Donation 5 Other (S	(pecify)			hens (/31/		Boyki	•				
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if item 27 is eny injury or other tre onca.		21. Signature of Funeral Service	Licensee		22	2. Name and	Address	s of Facilit	y Do	naldsor	Funer	al Hon	ne, P.A	Α.		
	202 e d		23a. Part1. Enter the disease, or	- Br	M00773						Laurel		20707	Approximate	Ď		
8760,	death certificate be executed e attending physician and idea as the burial-transit	dicai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	as a consequen as a consequen as a consequen	ce of):	V S) W		<u> </u>	<i>> u</i>	ng .			s mer	0199		
Вох 68	certific nding p	n/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnancy		30					23d. D	ate of delive	ry			
o.	the character and a	Ď.	in the past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnan		3 □Ectopic pregnancy 5 □ Other (specify)					Month Day Year			ear			
of Vital Records, P.	requires that I een signed by nould be deta		Part II. Other significant condition	ons contributing to deal	th but not resultin	g in the u	nderlying ca	use giver	n in Part I.		23e. Did to	obacco use con	ntribute to th		eath?		
Ö	w req	Completed									24a. Was	24h	More autor	osy findings a	wadabla		
Re	The law ate has b bage 2 st	m d									autop		prior to con death?	npletion of ca	use of		
a	in: T ificate or, pa	Ö.	25. Was case referred to medica								1 ☐ Yes		1 🗆 Yes	2 No			
Ξ	Physician: The law this certificate has t ral director, page 2 s	o B	examiner?	Hospital: 1 ☐ Inp	estiont 2 🗆 ER	Outpatien	4 2 DO	Other			Check only o			TRIS			
of	g Phy er this	\vdash	27. Manner of Death	28a. Date of		b. Time of		c. Injury	at	-	ne 5 Resid	-	rred	HOM	NE-		
Division	nding ath. r: Afte e fun	Certification:	1 Statural 5 Pendin 2 Accident investi		Day Year)	Injury	м	Work?	? es 2.⊟1	No							
Vis	Atte	ifica	3 Suicide 6 Could 4 Homicide determ	ined 286. Place of	Injury - At home	, farm, str	eet, factory,	office		2	8f. Location (S		ber or Rura	Route Numt	DB1,		
	el or s afte si Dir	Sert	4 D Homicide	building	etc. (Specify)						City or Tow	m, State)					
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier Certifyir	g Physician: To the be Examiner: On the basi	est of my knowled	dge, death	occurred a	t the time	e, date and	d place, a	nd due to the	cause(s) and m	nanner as st	ated.			
	the H iin 24 the F iplete	Medicai	one)	and manne	stated.	and/or in				in occurre	d at the time, (ate and place	, and due to	the cause(s)			
	Veit To	2	29b. Signature and title of certifie	1) 72	A	i W	29c.	License		28		29d. Date sign	ed (Month, L	Day, Year)	Arl		
	5		30 Name and address of person	who completed cause	of death (Item 23	a) (Type,	Print)	DE	KA	(F	HIGH	IN the	1 NNA	Pouch	Mnziu		
12	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 8		istrar's Signature	has	,	av V	1 1 10	30	1/(4//	••)			
	**		MUULO	LUUI FEET	NA NA	127											

			Please Type or Print					•					
			For State of Mary State of Mary State Registrar		artment of F ctificate of	lealth and Mer <i>Death</i>	ntal Hygiei Reg.	2007	27533				
	TUL	ш	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death						
2	Physici:		Linda Lou Smith					25 2007	12:00 a M				
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death		4c. County of Dear					
7	LAGIIIII	Ĭ.	420 Burbank Court		Haletho	orpe		Baltimor	e				
67,	Funeral Director		5. Social Security Number $234-70-1436$ 6. Sex $^{1}\square$ M $^{2}\M$ F 7 Age (1	n yrs. last birthday) 58 Yrs.	If Under 1 Year Months Days	Hours Min. No	Date of Birth (Month, Day, Ye OV 29 19		thplace (State or Foreign buntry) yland				
	D .		Usual Residence of Decedent	- O: T					101111111111111111				
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ther, the Medical Examiner must be notified at	_	,	0c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No				
	a-fs	cto	MD Baltimore	Haletho	rpe				1 163 241140				
	th th	Funeral Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	ountry?				
	h wil	al	420 Burbank Court		21227	7		USA					
	ms ms	ner	11. Marital Status 12. Was Decedent Eve	er in U.S. 13.	Was Decedent of H	lispanic Origin? (Specify an, Mexican, Puerto Rica	Yes or No-	14. Race - Ame					
(0	fter r ite	Ē	1 ☐ Never Married 2 ☐ Married Armed Forces?	1	i res, specily cub. i∏ Yes 2X No		an, etc.)	Black, Whit	e, etc.				
036	urs a al", o Exan	by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:		ILIYES ZEINO	Specify:		hite					
ō	2 ho atur cal F	ted	15. Decedent's Education	16a. Deced	dent's Usual Occup	pation	16b	. Kind of Business	Industry				
21215-0036	nin 7 nin "in Medi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. I	DO NOT use retire	during most of working d)	Own Hor		nα				
712	with	E 0	12	Home	maker			JWII IIOINE					
P	filec Hyg othe ent,	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name (Fi	irst, Middle, Maid	den Surname)	-				
an	ld be ental ked k	To B	Charles L. Llewellyn			Betty .	J. Sha	adwell					
Maryland	shoul nd M mar	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street	and Number or Rural R	oute Number, Ci	ty or Town, State, .	Zip Code)				
Z	id 2 Ith au 27 Is trau		Melissa Ridge, daughter	308	7th Aveni	ie, N.E., G	len Burr	nia MD	21060				
é,	1 ar Hea tem 2		20a. Method of Disposition	20b. Place of Dispo		Date		Location - City or					
Baltimore,	ages nt of t: If ii		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	' i	2007 Da	1+	MD						
뜶	it. P		4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 8/27/2007 Baltimore, MD 21. Signature of Funeral Service Licensee										
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show a mortant: In item 27 is marked other than "hatural", or items 23a or 28a-f show a mortant in injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee A. Williams 22. Name and Address of Eacility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228										
			23a. Part1. Enter the disease, or complications that caused th shock, or heart failure. List only one cause on each line.	e death. Do not ent	er the mode of dyi	ng, such as cardiac or re	espiratory arrest,		Approximate Interval Between				
	Physician		Immediate Cause (Final disease or condition resulting in death)		Onset and Death Vear								
10	/Medical		resulting in death) Due to (or as a continuous)		Jear								
8	Examiner		Sequentially list conditions b. Thyroid (vear							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Lumbar po										
	cutec Id ransi	xamine	that initiated events C.		year								
oʻ	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	EX	resulting in death) Last Due to (or as a c	, ,									
68760	e bu	cal	Hypertens	sion					years				
68	ificat g phy as th	edi						1					
Вох	ndin	₹.	Physician/Medical	N/	IF FEMALE: 23c. If yes, outcome pf		7			23d. Date of de	livery		
Ď	death atte	icia	in the past 12 months? 1□ Ves 2 📆 No.]Ectopic pregnanc] Other <i>(specify)</i> _	У		Month	Day Year				
P.O.	the (ıys	9 ☐ Unknown										
	that led b	<u>P</u>	Part II. Other significant conditions contributing to death but r	co use contribute t	o the cause of death?								
Records,	uires I signe	Completed by	Hypercalcimia, Osteoporosis				1 ☐ Yes	2 □ No 3 □ P	robably 4 X Unknown				
Ö	w requires been six	ete	Hyperlipidemia, Anxiety, Dep	roggion			24a. Was an	24b. Were a	utopsy findings available				
Type: Tipidelilia, AixTety, Depression									completion of cause of 2 □ No				
To go a local desired to the second s													
Ζï	Physiclan: The la rthis certificate had ral director, page 2	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death (Check only one) Hospital: 1 Inpution 2 EP/Outpution 3 DOA Other: 4 Number 1 Doa 6									
ō	Phys this al dii	<u>1</u>	1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 27. Manner of Death 28a. Date of Injury	2 ER/Outpatier	K 3 DOA	4 Li Nursing Home	5X Residence I. Describe how i		ecify)				
5	ling After funer	io	1 X Natural 5 ☐ Pending (Month, Day Y		Wo	rk?]Yes 2 □ No	. Describe now	injury occurred					
Sic	Attending r death. ector: After by the funer	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of injury	- At home, farm, str			Location (Street	at and Number or F	Tural Route Number,				
Division or Vital	or A fter c lired in by	riff	4 Homicide determined building, etc.	(Specify)	oot, ractory, unice	201.	City or Town, S	State)	arar riodio Nunidoi,				
	pital ours a eral	S	29a. Certifier 1 X Certifying Physician: To the best of	my knowledge, deet	h occurred at the t	ime date and place and	due to the cour	ea(e) and manner of	s stated				
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Lifrector, After thi completely filled in by the funeral	Medical Certification:	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of example and manner state	xamination and/or in	vestigation, in my	opinion, death occurred	at the time, date	and place, and du	e to the cause(s)				
	thin the	Mec	29b. Signature and title of certifier		29c. Licens	se number	29d.	29d. Date signed (Month, Day, Year)					
	F.≥ F. 8		Alla . Ras	luk	1								
	10		00000,000	1		54749		August 2	7, 2007				
(l O		30. Name and address of person who completed cause of dea Allen Reilly, MD, 801 Toll			Frederick, 1	MD 21701	L					

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 2 8 2007

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1 200**7 Physician** AUG 21 CHAYA SIMMONS 2:13 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY NATIONAL NAVAL MEDICAL CENTER BETHESDA If Under 1 Year If Under 24 Hrs.

Marke Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Months 1 □ M 2 🖾 F 30 Aug. 21, 2007 Director None Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event." 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Director Elkridge MD Howard 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 6853 Old Waterloo Rd., Apt. 170

Marital Status

12. Was Decedent Ever in U.S. Armed Forces?

1 T Never Married 2 Married 1 Types 2 1 No 21075 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No 1 ☐ Yes 2 No Specify: Specify: White ò 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A U 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wesley Andrew Simmons Suzanne Elizabeth Richmond ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6853 Old Waterloo Road, Apt. 1707 Elkridge, MD 21075 19a. Informant's Name/Relationship (Type. Print) Wesley A. Simmons/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8-27-07 01d Tennent Tennent, NJ 5 ☐ Other (Specify) 4 ☐ Donation Metropolitan Funeral Service 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 5510 Vine Street, Alexandria, VA enn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** EXTREME PREMATURITY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown certificate has been signed by rector, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 1□ Yes 2 No 2 No the Hospital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 1 Yes 2 No 1 X Inpatient Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 XNatural 5 Pending investigation 1 Yes 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0101238735 (VA) M) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 KATHY L. KYSER LCDR MC USN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

ORIGINAL

Registrar

DHMH 17 Rev 1/2001

			State of Maryland / D	epartment of F Certificate of			giene 0	7 27535				
	M. E.		1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month		3. Time of Death				
	Physici: /Medic	- 2 1	Charles Henry Schoonover			August		10:30 A ^M				
)	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	r Location of Deat	h	4c. County of [Death				
2	And a set of property of series.		Heartland Nursing Home	Hyatts		1	Prince	George's				
	Funeral		5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birt.	Months Days	If Under 24 Hrs Hours Min.		7, Year) 9.	Birthplace (State or Foreign Country)				
ķ,	Director		467-33-6907 44 Usual Residence of Decedent			pury 10	, 1903 1	exas				
	yland Iow at		10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits				
	a-fsh	ctor	Texas Cameron Harlin	gen				1 XYes 2 No				
	e not	Jire	10e. Street and Number	10f. Zip Code			10g. Citizen of Wha	t Country?				
	ath w	Funeral Director	210 E. Matz	7855			U.S.A.					
	er de items	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		American Indian, Vhite, etc.				
50	within 72 hours after death with the Maryland tene. Itan "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by F	1 ŽM. Never Married 2 □ Married 1 □ Yes 2 127 No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 H No	Specify:		Specify: White					
2-003p	2 hou atura cal E	ed	15. Decedent's Education 16a.	l Decedent's Usual Occup	ation		16b. Kind of Busine	ess/Industry				
2	hin 7.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done life. DO NOT use retired	during most of wo d)	rking						
7	d with	Ö	Ziemenkary (e 12)	Software			Comput	er				
yland	tal Hy d oth	Be (17. Father's Name (First, Middle, Last)				Maiden Surname)					
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e)	1 and Healt em 2 ther 1			02 E. Harri		, Harlin	gen, TX /	·				
Ö	ages nt of l		i Bunai 2 Ucremation 3 Unemoval from State	Disposition (Name of y, crematory or other place		7-07						
Dalillimo	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inmportant: If tiem 27 is marked other than "natural!", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		4 □ Donation 5 □ Other (Specify) Ashlan. 21. Signature of Funeral Service Dicensee	d Cemetery 22. Name and Addre	ss of Facility		Harling					
ם	Dep Imp		Mion Stand O	Trinity F	uneral C	hapel	Harlingen	, TX 78550				
	15		23a. Fart . Enter the disease, or complications that caused the death. Do n					Approximate Interval Between				
F	Physician		sho , or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	LMONEARY	ARR	EST		Onset and Death				
	/Medical		resulting in death)	f)·								
	Examiner		Securentially list conditions by MYDCAR	DIAL IN	GARCI	Done						
	sit sit	iner	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying	f):	Palaco.	1 6 1	CANCER					
	xecut and il-tran	Examine	Cause (Disease or injury that initiated events resulting in death) Last	111C C30	MHGEN	CATO	TCER					
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00	ifficate g phy.		0,									
Š	anding use	Physician/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy	0.DE-11			23d. Date of	delivery				
0	deat le atte	sicia	in the past 12 months? 1 Ves 2 No 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	/		Month	Day Year				
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'n	res th igned be de	by	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause giv	en in Part I.	23e. Did tobacco use contribute to the cause of death						
cords,	requi	ted				1 1 1	′es 2 No 3	Probably 4 🖔 Unknown				
בַּבַ	e law has b e 2 st	Completed				24a. Was a autop	sv prior	e autopsy findings available to completion of cause of				
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7	slciar certif recto	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	notiont 3 DOA Oth		ath (Check only or						
5 i	r this eral di	5	27. Manner of Death 28a. Date of Injury 28b. T	patient 3 DOA	4 L3 Nursing F		ence 6 Other (Specify)				
	nding th. :: Afte e fune	tion	1 X Natural 5 □ Pending (Month, Day Year) Ir 2 □ Accident investigation		ḱ? Yes 2 ∐ No		,,					
2	Atte	iffica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)	m, street, factory, office		28f. Location (S	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
5	tal or rs afte al Dir	Certification:	building, etc. (Specify)			Oily or Yow						
:	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after deep. Within 24 hours after deep. After this certificate has been signed by the attending tompletely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
:	vithin To the	Mec	29b. Signature and title of certifier	29c. Licens	e number		29d. Date signed (Month, Day, Year)					
1	~		Virginia	D44	6529		AUGUST 24 2002					
	77		30. Name and address of person who completed cause of death (Item 23a) (100-1	- 1 0007				
0				nover Pkwy.	Greenb	elt, MD	20901					
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Coartes								

DHMH 17 Rev 1/2001

/lar	tin Kevin Sha		I- For State	ate of Maryl		artment of rtificate of			Menta	al Hyg	giene	Reg. N	No.	1117 27	53
	Physicia		Registrar 1. Decedent's Name (First, Middle,Last)							2.	. Date of Month			3. Time of Death	
Иe	dical Exami		Martin Kevin Shaffer								August	18, 2	007	1351 hrs	
			4a. Facility Name (if not institution Bowie Health Center	on, give street and n	umber)	2	Bowie	own, or Lo	ocation of	Death			4c. County of D Prince Geo		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under	24Hrs.	8. Date o	of Birth(N		. Birthplace (State or	
	Director		216 72 8786	1 X M 2 F		.7 ' Yrs.	Months		Hours	Min.			1959 F	oreign Country) MD	
ς.	any	- [Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Locati	on							10d. Inside City I	Limits
	* .		Maryland Princ	e George'		Bowie								1 Yes 2	No
	laryland 28a-f show at once,	횴	10e. Street and Number				10f. Zip (Code		-	_	10g.	Citizen of What	Country?	
.)	the Ma a or 2 tified	Director	14908 Night	hawk Lane	2			2071	6		4.	· U:	nited St	tates'	
	with ms 23 be no		11. Marital Status		ecedent Ever in t		s Deceder es, specify						14. Race - A White, e	merican Indian, Black,	
	or ite	Funeral	1 Never Married 2 N	1 Y Yes	2 No					r acitort	rearr, etc.	,			
	rs after rral", miner	à	3 Widowed 4 X Di	vorced If Yes, Give Your Dates:		16a. Deceden	Yes 2			ind of wo	rk done	T16	Specify: Sb. Kind of Busin	White ess/Industry	
	2 hour	Completed	Elementary/Secondary (0-12)		(1-4 or 5+)		ost of work								eret car
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	5-0036 iled within 7 Hygiene. I other than the Medica		17. Father's Name (First, Middle	e, Last)				18					den Surname)		
	more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. ont. If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at ourse.	o Be	UNKNOWN 19a. Informant's Name/Relation	ohie (Tiese Drint)		10h Mailin	Addross	(Stroot			e Arg		r City or Town	State, Zip Code)	
	MD 2121 d 2 should be f Ith and Mental n 27 is marked aumatic event.	۲	Kristina Shaf					,					, MD 207		
	nore, MD 2 ages 1 and 2 shoul at of Health and IN t: If item 27 is no other traumatic		20a. Method of Disposition		20b	. Place of Dispos	ition (Nam				Date 14,			ity or Town, State	
	MOFe Pages l ient of H int: If r other		The second second	n 3 Removal		crematory or oth 1 ington		ono1	Come		200	7	Arlinat	on Virginia	,
	Baltimore, permit. Pages la Department of He Important: If ite	ŀ	4 Donation 5 Other S 21. Signature of Funeral Service	pecify: bicensee	A1	22. N	lame and	Address	of Facility	Lee	Y		Home.In	nc. 6633 01	1 <u> </u>
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	Physician ////wedican	5 H3	23a. Part I. Enter the disease, of failure. List only one cause	e on each line.						rdiac or i	respirator	ry arrest,	, shock, or heart	Between Onse	
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			Sequentially list conditions,	b			_		_						
		nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		a consequence	Of):								_4	
	executed an and al - transit	Examine	events resulting in death) Last	Due to (or as	a consequence	of):					_				
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	Sox 68760 death certificate b e attending physic	sician/Me	IF FEMALE: 23b. Was decedent pregnant in	230. II yes	s, outcome of pre	griancy	etal death	3	Ectopic	pregnan	су		23d. Date of de Month	elivery Day Yea	ar
	x 6 th cert ttendir r use a	icia	past 12 months?	-1	gnant at time of	dooth	ther (Spec	cify)							
	Bo he dea the a	Phys	Part II. Other significant cond		nown	recoulting in the	undorlying	nauco di	von in Pa	et I	230	Did toba	acco use contribu	ute to the cause of dea	th?
	cords, P.O. B law requires that the d has been signed by the should be detached	b	rattii. Other significant cond	ations contributing	to death but not	resulting in the t	undenying	Cause 91	veri ii i a		1			Probably 4 🗸 Unki	
	rds requi	Completed										Was an autopsy		ere autopsy findings av or to completion of cau	
	eco he law ate has age 2 si	ome						-				performe Yes 2		ath? ✓ Yes 2	No
	Vital Recaysician: The this certificate director, page	o ·	25. Was case referred to medic						of Death ((Check o	nly one)				
	Vit hysici this c	To B	examiner? 1 ✓ Yes 2 No	Hospital: 1		/ ER/Outpatien	h	٠,,	Other 4		Home			Other:	
	Division of Vital Records, P.O. Box 6876. To the Bospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b			(Mos	te of Injury nth, Day,Year)	28b. Time of	Injury		y at Work es 2	l l	28d. Des	cribe ho	w injury occurred	1	
	livisior I or Attend after death Director:	Certification:	3 Suicide 6 Co	uld not be		home, farm, stre	et, factory	, office bu	uilding, et	c. :		tion (Str		or Rural Route Number	er, City
_	To the Hospital within 24 hours. To the Funeral completely filled		4 Homicide 29a. Certifier	Physician: To the b		adae death occu	rred at the	time da	te and nia	re and r	due to the	e cause(s) and manner a	s stated.	
10	thin 24 the F	Medical		aminer: On the basi	s of examination										
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	1			(1 N	11.12			O.C.N	Л.E.			_	August 19, 2	2007	
	D		30. Name and address of person	//	-		nn C4	nt Dalt	imere '	MD 244	201				
	V			eputy Chief Med	dical Examin Regeral's Signa		nn Stree	કા, ⊭alt	imore, I	IVIU 272	201				
	S Reais		31. Date filed (Month, Day, Year	0 2007	rar s Signa	ature K. 6	harts	,							

			1 - For State Registrar	State of N	vlarylan 		rtment of H rtificate of I		d Mental Hy	rgiene (07	2753
E	Physici /Medi		1. Decedent's Name (First, Middle, Last) Ruth Miller Ste						2. Date of Di Month 08	Day 23	Year 2007	3. Time of Death $1\!:\!00^{P\text{M}}$
1	Examir		4a. Facility Name (If not institution, give s 691 Winding Strea		#102		4b. City, Town, or Odento:		eath	4c. County	of Death	
	Funeral Director		226-26-08/3	7. A		as <i>t birthd</i> ay)	If Under 1 Year Months Days	If Under 24 I	Hrs. 8. Date of Bi (Month, D 10-26-	rth ay, Year)		ace (State or Foreign y) VA
	Aaryland f show ed at	ō	Usual Residence of Decedent 10a. State 10b. County MD Anne Art	1 - 1		, Town or Lo					10	d. Inside City Limits 1 ☐ Yes 【☐ No
	with the Na or 28a-	Director	10e. Street and Number			Odento	10f. Zip Code			10g. Citizen of		y?
036	be filed within 72 hours after death with the Maryland that Hyglene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	691 Winding Strea 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	IM Way 12. Was Deceder Armed Force: 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	s? XINo		211 Vas Decedent of Hi f Yes, specify Cuba ☐ Yes 2 X No		? (Specify Yes or No uerto Rican, etc.)	0- 14. Rad Blad	S.A. ce - America ck, White, e	tc.
1215-0036	ithin 72 ho ne. nan "natur Medical j	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4o	r 5+)	(Give	lent's Usual Occup kind of work done o OO NOT use retired	during most of	working	16b. Kind of B	usiness/Indu	ustry
Ind 21	led tygi her t, t	Be	12 17. Father's Name (<i>First, Middle, Last</i>)				Homemake		Name (First, Middle		wn Hon	ne
Maryland 21	2 should and Mer is marke aumatic	ဥ	William Gil Mille 19a. Informant's Name/Relationship (Ty)	pe. Print)				and Number o	Miller Rural Route Numb	per, City or Town,	, State, Zip (Code)
saltimore, r	m = 0		Mr. Gregory L. Ste 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	•	20b. Pi	lace of Dispo emetery, cren	Idlewild sition (Name of natory or other place Nat. Cen	e)	Date	20c. Location	- City or Tow	n, State
Baitir	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service License	ee	Hor	22	. Name and Addres	s of Facility	-06-2007 Singletor	Ft. My Funera Irnie, M	1 Home	P.A.
	Physician /Medical Examiner		23a. Parl 1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each	ed the death	Lone	er the mode of dyin	g, such as car		arrest,		Approximate Interval Between Onset and Death
		Examiner	Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		as a conse 🚚							
08/00,	ificate be executed g physician and as the burial-transit	edical E		Due to (or a	as a consequ	ence on:						
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours affect death. Within 24 hours affect death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Fetal at time of de	death 3	Ectopic pregnancy Other (specify)				ite of deliver	y Day Year
cords, F	equires that en signed b ould be deta	by	Part II. Other significant conditions cor	tributing to death	but not resu	lting in the ur	derlying cause give	en in Part I.		tobacco use cont Yes 2 No	tribute to the	
	n: The law re icate has bee r, page 2 sho	Completed							24a. Was auto perfi 1 Yes	psy ormeg?	prior to com death?	sy findings available pletion of cause of
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	nysiclar nis certif director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 🗌 Inpa	tient 2 🗆 E	ER/Outpatien	3 DOA Othe		Death (Check only)		ner (Specify)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide		Day Year)		28c. Injury Work M 1 1	vat ?? Yes 2 ∐ No	28f. Location (how injury occur		Route Number,
2	4 hours after thous after thous after thous after thous after thous after thousand the thousand		29a. Certifier 1 Sertifying Phys	ician: To the bes	etc. (Specify st of my know of examinat	vledge, death	occurred at the timestigation, in my o	ne, date and pl	ace, and due to the	e cause(s) and made	anner as sta	ted.
	To the I within 24 To the I complete	Medical	one) 29b. Signature and title of certifier	and manner	stated.	>	29c. License			29d. Date signe	d (Month, D	
1.	5		30 Name and address of person who co Russell DeLuca, M			23a)(Type, F		Glen I	Burnie, M	D 21061		

State Registrar 31. Date filed (Manth, Pay, Year) AUG 2 8 2007

3. Registrar's Signature Coule

			1- For State Registrer	te of Maryland / Depa	artment of H	ealth and M Death		ene ()	07	27538
	D		Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day	Year	3. Time of Death
	Physici /Medic		Kendra Arlene	Scott			August 1	8, 200		7:36 A M
	Examin		4a. Facility Name (If not institution, give street as	nd number)	4b. City, Town, or				y of Death COMEN	.,
			Holy Cross Hospital 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Silver	Spring If Under 24 Hrs.	8. Date of Birth			y ace (State or Foreign
	Funeral Director		578-99-5595 1 M 20	XF 36 Yrs.	Months Days	Hours Min.	Jan 5, 1	971	Count	ington, DC
	hours after death with the Maryland turet', or ttems 23a or 28a-f ehow at Exprimer mast be notified at		10a. State 10b. County	10c. City, Town or L					10	d. Inside City Limits
:	Mariting	cto	MD Montgomery	5110	er Spring		·			1 Yes 2 □ No
:	be filed within 72 hours after death with the Marylan Hygiene. do ther then "natural", or thems 23a or 28a-f show or ther then "natural" or the modified at event. It a Madical Examinating the notified at	Funeral Director	13837 Castle Blvd #11		10f. Zip Code 20904		10	g. Citizen of		ry?
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ar	s 1 and 2 should I Health and Mer Item 27 ie marke other traumatic	-	19a. Informant's Name/Relationship (Type, Prin	19b. Mail	ing Address (Street a	and Number or Ru	ral Royte Number,	City or Town	n, State, Zip	Code)
Ž	and 2 lealth a m 27 ic		Sherrell Eley/mother	-Oxon	H111 M	20745				
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remova		osition (Name of ematory or other place			0c. Location	_	wn, State
Ě	Pag ment tant: I		4 ☐ Donation 5 ☐ Other (Specify)	Maryland	Nat. Cem			Laure		C
gal	permit. Pages 1 Department of H important: if ite eny injury or ot		21. Siguature of Financial Service Lice		22. Name and Address 821 14th					
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	To the Hospital or At within 24 hours aftar of To the Funeral Directompletely filled in by	Medicai C	(Check only 2 Medical Examiner: O	To the best of my knowledge, dean the basis of examination and/or and manner stated.	ath occurred at the tir investigation, in my o	me, date and place pinion, death occi	a, and due to the caured at the time, da	ause(s) and rate and place	manner as si e, and due to	ated. the cause(s)
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(2	3	30. Name and address of person who complete Smitha Bhikkaji, MI	1500 Forest G	alen Road,	Silver	Spring, N	1D 20	910	
		ate	31. Date filed (Month, Day, Year) AUG 2 8 2007	32. Registrar's Signature	34 /2)				_	
	Regist	rar	AUG 4 0 LUUI	Sept to the sept of the sept o	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician 2206 PM 08 Thomas Eugene Sexton 25 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Vicamica egional Medical 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 09/10/1968 Birthplace (State or Foreign Country) Security Number 6. Sex **Funeral** Days 1 3 M 2 □ F 360-72-7834 38 Director CO Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Wicomico MD Salisbury TYTYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 Overlook Drive, Apartment 2B 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes **2XX**No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No White Specify: <u>Ş</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Photographer Photography Company 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David L. Sexton Barbara Paprocki J. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Sexton / Mother 1608 25th. Avenue, Rock Island, IL 61201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 8/31/2007 Calvary Cemetery Rock Island, IL 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 Fast Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown þ contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 within 24 hours after death To the Funeral Director: the

death with the Maryland

Maryland 21215-0036

Baltimore,

State Registrar 29b. Signature and itle of certifier

31. Date filed (Month, Day, Year)

6

30. Name and address

DHMH 17 Rev 1/2001

32. Registrar's Signature

of person who completed cause of death (Item 23a) (Type, Print

29d. Date signed (Month, Day, Year)

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ORIGINAL

07-06515

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

Norman Richard			State of	Maryland	/ Depart	tment of l ficate of l	Health	and Ment	aı Hygie		21	3117	2751
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Wedical Examin		la. Facility Name (i	f not institution, give s	reet and number)	UI .	b. City, Tow	n, or Location o	f Death	<u> </u>	4c. County of De		
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ith the Maryland 23a or 28a-f show notified at once	읥	1475 Mo	<u>ordor Lar</u>	1 <mark>e</mark> 12. Was Deceder	nt Ever in U.S	. 13. Was	2.1 s Decedent	076 of Hispanic Orig	in? (Specif	ý Yes or No-	14. Race - Ar		dian, Black,
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nora ages l nt of l other			XXCremation 3	Removal from S				atory	08/27	7/07 H	Baltimo	ore,	MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Méntal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Exampler must be notified at once.	*	21. Signature of F	Other Specify: uneral Service License	е		22, N	Name and A	ddress of Facilit	eral	Home.	Inc.		1D 21229
Per Per Dept in		Made	22			4	107	Wilken	s Ave	enue I	Baltimo	ore M	1D 21220 proximate Interval
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COT law ! e has !	ם									perform		ath? ✔ Yes	2 No
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Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only one)	Certifying Physici Medical Examiner	an: To the best of	of my knowled examination a	dge, death occ and/or investig	urred at the ation, in my	time, date and opinion, death	place, and o occurred at	the time, date a	(s) and manner and place, and du	is stated.	use(s)
To the within To the comple	Medical	20h Circotuse 6		and manner stat	ted.			. License numb			29d. Date signe		
	2	290. Signature	nd title of certifier	$\propto M$	1			O.C.M.E.]	August 23,	2007	
		C SIK	ddress of person who	nompleted source	of death (Ites	m 23a)							
10		30. Name and a Susan Ho		stant Medica	I Examine	r 111 Pg	enn Stree	et, Baltimore	, MD 212	201			
	State			E9	istrar's Signa		and						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend 15,16a-b,17,18,19a-b,20a-c,22, perfff, 88/1 | Certificate of Death Red. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician THOMPSON Kevin 01:59 M 2007 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Balhinove, MO Trauma Center, Univ of Marshall asalkinore Shock | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | Min. | July 17, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Country) **Funeral** 1 M 2□F 48 Director 215-84-0335 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show at 1√∏Yes 2□No be notified MD Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21217 1315 Carey Street USA Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Black, White, etc. Examiner 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: black ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the M once. Baker Bakery unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be ပ James Carroll Thompson Martha Regina Butler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9902 Tailspin Lane Apt F. Middle River, MD 21220
22 S. Greene Street Baltimore, MD 21201 19a. Informant's Name/Relationship (Type. Print) **Ebony Thompson—Daughter**University of Md Rospital 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 3₩Other(Specify) in state 9/8/ 2007 Metro Crematory, Inc. Baltimore, MD 22. Name and Address of Facility The Derrick C. Jones F.H., State Anatomy Board 655 W. Baltimore S. Wade, Director 21201 **21215** low Baltimore, MD 4611 Park Hgts. Ave. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician neamon disease or condition resulting in death) /Medical Due to (or as a consequence of): 22hrs **Examiner** Sephic Sequentially list conditions, if any, leading to immediate cause. Enter United, if Cause (Disease or injury Due to (or as a or nsequence of): Examine or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending within 24 hours after used...

To the Funeral Director: After the full of the 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

C. 6-egg,

AUG 2 8 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1823 7

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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. 3	142		Decedent's Name (First, Middle, Last)		Timodio or i		2. Date of Death	J. 140.	3. Time of Death
	Physici		Joan Carol Tawney				Month August	26, Year 2007	
A	/Medic Examir		4a. Facility Name (If not institution, give street and numb	per)	4b. City, Town, or	r Location of Deat		4c. County of Death	
			3706 Oakfalls Way		No	ttingham		Ba1	timore
where.	Funeral		5. Social Security Number 6. Sex 7	. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth	9. Birth	place (State or Foreign ntry)
	Director		215-42-9124 ^{1□ M 2} XF	63 Yrs.	Months Bays	Tiodis iviii.	May 30, 1		Maryland
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Ž	thould the mark mark	은	19a. Informant's Name/Relationship (Type. Print)	19h Mailir	ng Address (Street		sephine Mo	CGUITE City or Town, State, Zi	a Cadal
Z	nd 2 s Ith ar 27 is trau		Louis Tawney (Husband)					Maryalnd	
re,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I once.		20a. Method of Disposition	20b. Place of Dispo	sition (Name of	-		c. Location - City or T	
E O	Pagesent o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)	ate	natory or other plac	i	0/2007 13	. 1	L L.
Baltimore,	mit.	ŀ	21. Signature of Funeral Service Licensee		Cemeter Name and Addres			altimore, I Funeral Ho	
Ö	permi Depar Impor any ir		Defaure Ri	rekar 97	705 Belai:			n, Marylan	
水	*		23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	sed the death. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory arrest	t,	Approximate Interval Between
V	Physician		Immediate Cause (Final disease or condition		Lenken			1	Onset and Death
	/Medical Examiner		resulting in death) Due to (or	as a consequence of):					a rijec.
3.	п	_	Sequentially list conditions, b.						
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	as a consequence of):				_	
	al-tra	xar	that initiated events	as a consequence of):					
8760,	ficate be executed physician and s the burial-transit	dical							
9	ifficat g phy as the	ediç	0.						
Вох	The law requires that the death certifite has been signed by the attending age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outco		Je			, 23d. Date of deliv	ery
Ü.	deat e atte	icia	1 Yes 2 No 4 Pregnar	it at time of death 5]Ectopic pregnancy] Other <i>(specify)</i>			Month	Day Year
P.O.	at the by th tache	hys	9 Unknown 9 Unknow	n			7		
	res tha	by F	Part II. Other significant conditions contributing to deat	h but not resulting in the ur	nderlying cause give	en in Part I.	23e. Did tobac	cco use contribute to	he cause of death?
ord	w requir been si should I						1 ☐ Yes	2DNo 3□ Pro	oably 4 □Unknown
Records,	has be	Completed					24a. Was an autopsy	24b. Were aut	ppsy findings available mpletion of cause of
<u> </u>		Con					performe 1∐ Yes 2	d? death? No 1 ☐ Yes	•
Vital	nystcian: Thatis certificate director, pag	Be	25. Was case referred to medical examiner?		1-11		ath (Check only one)		
	Physical this call direct	ို	1 Yes 2 No Hospital: 1 Inp			4 Li Nursing H		e 6 ☐Other (Speci	5)
Division or	ding Ph h. After thi funeral o	jo	- Tatalal	Injury 28b. Time of Day Year) Injury	Work		28d. Describe how	injury occurred	
S	ten tor; the	cat	2 Accident investigation 3 Suicide 6 Could not be 28e Place of	injury - At home, farm, stre		Yes 2 □No	20f Location (Stron	et and Number or Run	of Pouto Number
<u>></u>	after Dire	Certification	4 ☐ Homicide determined building	, etc. (Specify)	set, idotory, office		City or Town, S	State)	ar noute ivariber,
	spita nours nera y fille		29a. Certifier Certifying Physician: To the be	est of my knowledge, death	occurred at the tim	ne, date and place	e, and due to the caus	se(s) and manner as	tated.
	To the Hospital or Al within 24 hours after d To the Funeral Direc completely filled in by	edical	(Check only one) 2 Medical Examiner: On the basi and manner	s of examination and/or inv	vestigation, in my o	pinion, death occu	urred at the time, date	and place, and due	o the cause(s)
	To t To t	Ž	29b. Signature and title of certifier		29c. License	number	29d	. Date signed (Month,	Day, Year)
•	Ti		Chattle Klan MD		רוע	912	<i>H</i>	ugust 27	2007
11	y /		30. Name and address of person who completed cause of	of death (Item 23a) (Type,	Print)	ine R.	160	00 44	171
1			31. Date filed (Month, Day, Year) 32 Reg	of death (Item 23a) (Type, I	2 BODE	THE CHILL	TIMORE	11) 2/0	231
	Stat Registra		AUG 2 8 2007	we to so	342				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 2007 23, Benjamin Michael Turner, Jr. Aug. 4c. Counfy of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Maryland Masonic Homes Cockeysville Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Dec. 28, 1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 X M 2 □ F 86 219-16-8662 Florida Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2515 Lawnside Road 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 TYes 2 □ No If Yes, Give Year or Dates42 1 -46 1 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 ☐ No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life, DONO! use retired! Accountant College (1-4or 5+) Elementary/Secondary (0-12) Accounting/Law 12 and Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin M. Turner, Sr. Annie Mae Trent 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Bynum Turner/wife 2515 Lawnside Road Timonium, MD 21093 20b. Place of Disposition (Name of Dulaney Valley 20a. Method of Disposition Date 20c. Location - City or Town, State Aug. 27, 1 X Burial 2 ☐ Cremation 3 Removal from State Memorial Gardens 4 Donation 5 Other (Specify) 2007 Timonium, Maryland 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 Bryan W Clary 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) Owhable days Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown

Physician /Medical Examiner

and

attending physician

signed by

After this certificate has

within 24 hours aner use..... To the Funeral Director: Aft

the Hospital

or Attending Physician;

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Completed

Be

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Certification:

Medical

the

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau once.

Physician

/Medical

Examiner

Funeral

Director

27 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

al Hygiene.

Mental and Mental Completed by Funeral Director

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPI

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Únknown

24a. Was an 1□ Yes 2 No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No

25.	. Was case referred to medical	
	examiner? 1 ☐ Yes 2 ☑ No	Hospita
27	Manner of Death	282

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of (Month, Day Year) Injury

3508

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

(Check only

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

LKCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending

investigation 6 ☐ Could not be

DZIY6X

29d. Date signed (Month. Dav. Year) 23/67

31. Date filed (Month, Day, Year) State

AUG 2 8 2007

32. Registrar's Signature

Boul

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State o	of Marylar	_	artment of F rtificate of			lental Hy	gien Reg. No		275Li
			Decedent's Name (First, Middle,	Last)						2. Date of De	eath		3. Time of Death
į.	Physici /Medi		Richard Brian T	aylor						AUGU:	ST D	Ž3,2007	4:55A M
	Examir		4a. Facility Name (If not institution, Saint Joseph			ter	4b. City, Town, o		of Death OWSO	n	40	County of Death	imore
	Funeral Director		5. Social Security Number 220-34-5594	5.Sex 1 <mark>∑</mark> M 2 □ F	7. Age (<i>In yr</i> s.	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Date 7-22-3			nplace (State or Foreign untry) ginia
	nd w		Usual Residence of Decedent 10a. State 10b. County		10c Cir	ty, Town or Lo	cation						10d. Inside City Limits
	Aaryla F sho	ō	Md. Baltim	ore	i	hite Ha							1 Yes 2 No
	the 128a-	Director	10e. Street and Number				10f. Zip Code				10g. C	itizen of What Co	untry?
	h with 3a or st be		1021 Bernoudy R	d.			21161				-	.S.A.	,
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 Ă Marrie 3 □ Widowed 4 □ Divorced	Armed F	24 No ive		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 Й No			ecify Yes or No Rican, etc.))-	14. Race - Amer Black, White Specify: Whi	e, etc.
2-0	72 h "natu	Completed by	15. Decedent's (Specify only highest			16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	ation during mos	st of worki	ng	16b. h	Kind of Business/I	ndustry
121	filed within 72 Hygiene. Ither than "nai Ithe Medic	E E	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire: :rician	d)			77.5	ah!a	
Q 5	filed Hygid Sther ent, th	ပိ	17. Father's Name (First, Middle, L	ast)		Erect	TICIAN	18. Moth	er's Name	(First, Middle		gh's n Surname)	
au	should be and Mental marked o	To Be	John Taylor							n Shea			
ary	g P E E		19a. Informant's Name/Relationshi	p (Type. Print)		19b. Mailir	ng Address (Street	and Numb	er or Rura	al Route Numb	er, City	or Town, State, Z	ip Code)
	and 2 ealth a n 27 is ier trai		Ruth E. Taylor				Bernoud	y Rd.	Whi	te Hall	, M	d. 21161	
Baltimore,	Page ment ant: If		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		State (cemetery, crei	sition (Name of matory or other place ervice Co	rn !	ء -8-27	oate -07	_	son, Md.	Γown, State
Salt	permit. Departr Importa any inj		21. Signature of Funeral Service L	censee		22	2. Name and Addre	ss of Facili	ity			1050 Yo	ork Rd.
	20280		23a Part I Enter the disease or o	omplications that	nouged the deal							.,Towson	,Md.21204
			23a. Part1. Enter the disease, or o shock, or heart failure. List o					ng, such as	s cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	O I OGEN (or as a conseq		BCK	_					
	Examiner						RDIAL I	NFAR	CTIO	N			
		ner	Se uentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a conseq	juence of):							
-	ficate be executed physician and is the burial-transit	Examiner	that initiated events	U			Y DISEA	SE					
Š,	oe exe Sian a uríal-	Ä	resulting in death) Last		(or as a conseq		YMPHOMA						-
8/60,	cate the physic the b	dical	'	d	11032/011	1140 1	11.15.1101.114						
O. Box 6	death certi e attending d for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	tcome pf pregna birth 2 □ Feta nant at time of c own	al death 3	Ectopic pregnancy Other (specify)	У				23d. Date of deli Month	very Day Year
ı,	requires that the een signed by th		Part II. Other significant condition	s contributing to d	eath but not res	ulting in the u	nderlying cause giv	en in Part I	l.	23e. Did t	obacco	use contribute to	the cause of death?
cords	w require been sig should b	ed b	SEPTIC SHOCK							1 🗆	Yes 2	2 <mark>⊠</mark> No 3□ Pro	bably 4 □Unknown
ပ္	law asb 2 st	Completed by	PANCYTOPENIA		_					24a. Was		24b. Were au	topsy findings available ompletion of cause of
r =	pa ate	Com								perfo 1∐ Yes	rmed? 2 X N	death? o 1 ☐ Yes	2' No
VITAI	Physiclan: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth		e of Death	(Check only o	one)		
0	Phys this	<u>۲</u>	1 ☐ Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatien		4 🗆 190		ne 5 Resi		6 □Other (Spec	ify)
0	ding h. After funer	tion	1 Matural 5 □ Pending 2 □ Accident investiga	(Mon	th, Day Year)	Injury	Wor	ya≀ k? Yes 2□		tou. Describe	now inju	iry occurred	
UNISION	Atten r deat ector	fica	3 Suicide 6 Could no	t ho	of injury - At he	l pme, farm, str	eet, factory, office		-	28f. Location (Street a.	nd Number or Ru	ral Route Number,
5	s afte al Dir	Certification:	4 ☐ Homicide determin	build	ing, etc. (Specil	<i>'Y)</i>			- 4	City or To	wn, Stat	e)	
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical	29a. Certifier (Check only one) 1 Certifying 2 Medical E	xaminer: On the b	e best of my kno easis of examina ner stated.	owledge, deatl ation and/or in	n occurred at the til vestigation, in my o	me, date ar opinion, dea	nd place, a ath occurr	and due to the ed at the time,	cause(s	s) and manner as nd place, and due	stated. to the cause(s)
ı	To t with To t	Z	29b. Signature and title of certifier	Lou	M.).	29c. Licens				29d. Da	ate signed (Month	(Day, Year)
	10		30. Name and address of person w		,								
	,	•			21 OSL			WSON.	, MAR	YLAND	2	1204	
	Sta Registr		atto	32. F	And LA C	B A	2218						
DIII	MH 17 Bay 1/0/		AUG 2	7 (AALL	Mary Comment	and the second							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Travers lyngra ququet 4:46 PM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnis anne arunde Baltimore Washington Medical Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**K**M 2□F Director 81 129-20-9591 June 28,1926 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified ≭t 10d. Inside City Limits Maryland Anne Arundel Director Pasadena 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8584 Creek Road 21122 U.S.A. by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Westinghouse Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Bernard J. Travers Lena Marlow Marlow 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Smith Travers (Wife) 8584 Creek Road, Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 □ Cremation 3 ☐Removal from State Meadowridge Mem Park 08-30-07 Elkridge, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Mary ind Maryland 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. In ediate Cause (Final sease or condition resulting in death) **Physician** CY 49 22 5 days /Medical Examiner shou Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ав а посведнесть об that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria nteretitial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Myslodusplasia Colon cancer , chronic Kenal Gilvie Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown chronic myelogenous leukemia 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an Jas page 2 s autopsy perform certificate l 2 No director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 Natural Injury death. e Funeral Director: A letely filled in by the fi 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

24 To the To the

> State Registrar

(Check only one)

29b. Signature and title of certifier

30. Name and address of person

STUart

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

JACOBS MD-

to completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

305

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Or.

000224

Glen Burnie.

29d. Date signed (Month, Day, Year)

4414T 25,2007

Hospitel

			State of Maryland / Department of Health and Mental Hygiene
			For State State Registrar Certificate of Death Reg. No. 2007 27546
	100		1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
	Physici /Medio		Trene Tolliver Woolfolk August 17, 2007 4:45 AM M
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
			13205 Taney Drive Beltsville Frince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
Ш	Funeral Director		5. Social Security Number 226-38-7648 6. Sex 1 M 2 F 90 Yrs. 7. Age (In yrs. last birthday) 90 Yrs. 1 Months Days Hours Min. 1 Months Days Year) 7-31-1917 9. Birthplace (State or Foreign Country) Virginia
uh.	often on said		Usual Residence of Decedent
	laryla shov	'n	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Prince Coorce C Reliable 11 □Yes 2 No.
	the N 28a-f notifie	Funeral Director	MD Prince George's Beltsville 1 □ Yes 2 🖾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	3a or	Ö	13205 Taney Drive 20705 USA
	death	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
36	s after or its amine	y Fu	1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No Specify: Specify: Specify: R1 a C k
Ö	hours tural" al Exa	ed by	Year or Dates:
15	nin 72 In "na Medic	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+)
212	d with	Com	5 Housekeeper Domestic Work
nd	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Z Za	d Men narke	2	Percy Tolliver Laura Taylor
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatlh and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. Print) Clara W. Scott/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13472 Ladysmith Road, PO Box 123 Milford, VA 22514
Baltimore,	s 1 ar f Hea iteπ 2		20a, Method of Disposition 20b, Place of Disposition (Name of Date 20c, Location - City or Town State
E	Page nent o int: if iry or		1 ဩBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Second Baptist Church Cemetery 8-23-07 Ruther Glen, VA
<u>a</u>	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility C. W. Edwards Funeral Home
	20 E # 9	(1.)	PO Box 395, Bowling Green, VA
eq.			23a. artil. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Cerebrovascular Disease Years Due to (or as a consequence of):
	Examiner		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury
	ecute and -trans	Examiner	trial militated events .
760,	ate be executed nysician and he burial-transit	cal E	Due to (or as a consequence of):
687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		d.
ŏ	h cert ending	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the post 10 protted 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 23d. Date of delivery
Vital Records, P.O. Box 68	e deat he att	sicie	1 Yes 2 No 9 Velocity Month Day Year
<u>Б</u>	d by t	Phy	9 LI ONKROWN
ds,	w requires that the dibeen signed by the should be detached	d by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes Mellitus II, Hypertension
CO	w requ	letec	
Re	The lav cate has page 2 t	Completed	autopsy prior to completion of cause of performed? death?
ā	sician: Th certificate rector, pag	Be C	Anemia, Hypothyroidism 1□ Yes 2☑No 1□ Yes 2☑No 25. Was case referred to medical 26. Place of Death (Check only one)
	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificatelly filled in by the funeral director.	10	examiner? 1 Yes 2 No
Division or	ding P. h. After t funera		27. Manner of Death 28a. Date of Injury 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Work?
<u>S</u>	death death ctor: y the	icat	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of injury. At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,
≥	al or A	Certification:	4 Homicide determined determined building, etc. (Specify)
	ospita hours unera ily fille		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	the the	ledical	one) and manner stated.
	vith on on	Σ	29b. Signature and title of certifier D28998 29c. License number D28998 29d. Date signed (Month, Day, Year) August 17, 2007
	. 1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
(0		Pritam Saini, MD 9101 Cherry Ln., #211, Laurel, MD 20708
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature
	Registra	ar	AUG 2 8 2007 Januar St. Aprile

		•	1 = For State Registrar	otato or mar	ylalla	Cer	tificate of	Death	a montani	Reg. No.	2007	27547
	Physicia /Medic		1. Decedent's Name (First, Middle, Last	ohn Wiede	rock				2. Date of D Month Augus	Day	2007	3. Time of Death 3:39 P M
}	Examin		4a. Facility Name (If not institution, give 8415 Bellona Lar	street and number)			4b. City, Town, o		eath	4c.	County of Death	ore
	Funeral Director		5. Social Security Number 6. Se 218-36-8986	x 7. Age ((In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of E Min. (Month, L May 18	Birth Day, Year) 3, 194	Cou	place (State or Foreign ntry) land
	ne Maryland 8a-f show ptified at	Director	Usual Residence of Decedent 10a. State 10b. County Md. Baltimo		Tow:	Town or Lo						1 0d. Inside City Limits 1 □Yes 2 No
	ath with the 23a or 2 ust be no	ral Dir	8415 Bellona Lane					.204			zen of What Cou USA	
020	urs after des al", or Items Examiner m	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:	er in U.S.		Was Decedent of H f Yes, specify Cub I ☐ Yes 2 🕱 No		? (Specity Yes or N Puerto Rican, etc.)	No-	 Race - Ameri Black, White, Specify: 	
0-0171	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)			(Give life. L	lent's Usual Occup kind of work done DO NOT use retire teel Work	during most of d)	working	16b. Ki	nd of Business/Ir	dustry
ylaliak	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Me	To Be Co	17. Father's Name (First, Middle, Last) George Wiederock					18. Mother's	Name (First, Midda Vivian	lle, Maiden Pool	Surname)	
Yall	and 2 sho salth and 1 27 Is m er traum	-	19a. Informant's Name/Relationship (T) Mrs. Carol Wiederoc						r Rural Route Num #317 Tows			
ווווסומי	Pages 1 ament of He rant: If Item		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Other (Specify))	1	top S	sition (Name of natory or other pla Service (o. 8-	Date -28-07		owson,	
ם	permit Depar Impor any in once.		21. Signature of Funeral Service Licens			22	Name and Address Ruck Tow 1050 Yor	ess of Facility Son Fur K. Rd.	neral Hom Towson, M	e, In d: 21	<u>2</u> 04	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ilitations that caused the cause on each line. a	conseque	Do not entonce of):	er the mode of dyi andia Hery	ng, such as car	rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
۵٬۵۵٬	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a of Due to (or a) Du		nce of):						
O. DOA O.	attendir for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf 1□Live birth 2 4□Pregnant at tii 9□Unknown	Fetald	leath 3	Ectopic pregnand Other (specify)	у		- 2	23d. Date of deliv	ery Day Year
L COL	quires that in signed by uld be deta	þ	Part II. Other significant conditions co	ntributing to death but	not result	ing in the ur	nderlying cause gi	ven in Part I.				he cause of death? bably 4 Unknown
	To the Hospital or Attending PhysIclan: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Completed							24a. Wa auf per 1 Yes	topsy rformed?	l death?	opsy findings available ompletion of cause of
A 116	sician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		-10	Otl	or:	Death (Check only			
5	iding Phys th. : After this funeral di	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Day)	2	R/Outpatien 8b. Time of Injury	28c. Inju	4 🗀 Nursii	ng Home 5 X Re 28d. Describ			fy)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury building, etc.	/ - At hom (Specify)	e, farm, str			28f. Location	n (Street an Town, State	d Number or Rui)	al Route Number,
	e Hospita 24 hours e Funera etely fille	Medical C		rsician: To the best of Iner: On the basis of e and manner state	xaminatio							
	vithin To th compl	Me	29b. Signature and title of certifier	<u> </u>			29c. Licens	se number		29d. Dat	te signed (Month	Day, Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard O. Acldo, M.D. 8415

31. Date filed (Month, Day, Year) AUG 2 8 2007

DO 59283

Bellona Lane, #216, Towson, MD 21204

August 28, 2007

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director,

31. Date filed (Month, Day, Year) Registra

DHMH 17 Rev 1/2001

OCME 2006

29b. Signature and title of certifier

30. Name and address of pe

Jack Titus MD.

son who completed cause of death (Item 23a)

Deputy Chief Medical Examiner

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

August 15, 2007

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 24, 2007 ear **Physician** 10:30 Jacqueline Louise Yommer /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore White Marsh 5510 Maudes Way If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 212 E 217-30-4163 71 March 30,1936 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2XXXNo Maryland Baltimore Middle River Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 U.S.A. 705 Compass Road, Apt. 204 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: Completed by White 3℃Vidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Service Cafeteria Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Cinquegrani John Della King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1828 Wilson Point Road, Baltimore, Maryland 21220 Janice Sparwasser (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard: 08/29/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A.
1407 old Eastern Avenue, Essex, Maryland 21221 21 Signature of Funeral Service Licensee 23a. Part1. Phiter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Adenocarcinon Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 26. Place of Death (Check only one) 25. Was case referred to medical Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Residence 2XXV0 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1XXXIatural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation after death. 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier DO058475 PHYSZUIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 , ally PHICKDELPHIA ROAD, BACTIMORE, NO 21237 PHTULP Day, Year) 32. Registrar's Signature 31. Date filed (Month, G 2 8 State DANKE Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 29d per dr., g870,08/30/07/hbate of Death 2. Date of Death 1 Depedent's Name (First, Middle, Last) 3. Time of Death Day Vear Physician Hone 0 08 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Age (In yrs. last birthday) General orchester Jorches Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**y** M 2 □ F Yrs. Director 214-28-8100 Mar. 21, 1928 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Director MD Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 507 West Appleby Avenue 21613 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: white Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) truck driver 6 rendering company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental Frank F. Arnie Katie Tjaden ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife Emma Arnie 507 West Appleby Ave., Cambridge, MD permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Mem. Park 8/13/07 Cambridge, MD 21. Signatu A Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. long 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician disease or condition resulting in death) Cerebrovascula days /Medical Due to (or as a consequence of): Examiner I.br. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-trar Due to (or as a consequence of): Physician/Medical that the death certificate attending phase as the IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by obstructive 1 ☐ Yes 2 No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 autopsy performed? res 2 No certificate has 1□ Yes **Division or Vital** Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 1 MInpatient Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)
August 9, 2007 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 408 Street M.D.

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed

Registrar's Signature

2007

			1 - For Amend Item 242		1,09/11/07	ertificat	e of L	Death	TIC IVIC	Re	g. No.) I	4/11/4
	Physici	an	Decedent's Name (First, Middle, La	st)					1 2	Date of Death Month	n Day	Year	3. Time of Death
	/Medi		CATHERINE		DAMS					AUG 8,	2007		1843 M
7	Examir	ner	4a. Facility Name (If not institution, giv		7 Ober			Location of	Death		4c. County of		
		46	Prince George 5. Social Security Number 6. S		I CTT (In yrs. last birtho			erly	4 Hrs. s	Date of Birth	PRI		GEORGES
	/ Funeral Director	ì	213-38-2774	□M 2 X F	87 Yrs	Months	Days	Hours	Min.	B. Date of Birth (Month, Day, NOV • 8	1919	9. Birthi Coul Ma	place (State or Foreign aryland
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	Location							10d. Inside City Limits
	Mary fah	ō	MD Prince	George	Bre	entwoo	ьd						1. No 2 □ No
	r 28e	Director	10e. Street and Number			10f. Zip				10	g. Citizen of W	hat Cou	ntry?
	h with		4101 Shepherd	Street			207	2.2					,
	dea	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	3. Was Deced			in? (Speci	ify Yes or No- ican, etc.)	U.S. 7 14. Race	- Americ	can Indian,
36	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "natural", or iteme 23a or 28e-f ahow any injury or other traumatic event, If a Medical Evarchiar must be inclined at ance.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 N If Yes, Give Year or Dates:	lo	1 Yes		Specify:	ruerto M	ican, etc.)	Specify:	, White,	
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Jar	2 sh and Is m raum		19a. Informant's Name/Relationship (,, ,						Route Number,			
e,	1 and Healtl em 27 ther t		Faith Adams-] 20a. Method of Disposition	Daughter	20b. Place of Di	1 She	per	d St		ntwood			
Baltimore, Maryland 21215-0036	nt of little or o		1⊠ Burial 2 ☐ Cremation 3 ☐		MD Nat	rematory or of	ther place		Dat		0c. Location - C		
를	artme orteni injury		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen)MD Nai	7			3/14,		Laure		MD ome, PA
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	14 1 - Sw		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each lin	the death. Do not e.	enter the mode	e of dying	, such as ca	ardiac or r	respiratory arres	st,		Approximate Interval Between
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ö	w require been si should t	Completed								:	2 110 3		aciy 4x10/iknown
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Ø	ilcien: Th certiticate rector, pag		25. Was case referred to medical							1 ☐ Yes 💥] No 1[Yes	2□ No
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101	g Physical this neral di		27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time		Bc. Injury	at Nursi	28c	5 Residen	injury occurred	(Specify	′)
<u>0</u>	ttending death. tor: Atter the funer	atic	1 Natural 5 Pending 2 Accident investigation	(World), Day	Year) Injur	М		r es 2 □ No					
DIVISION	spitel or Attending Fours after death. eral Director: Atter filled in by the funer:	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, farm, (Specify)	street, factory,	office		28f	Location (Stre City or Town,		or Rura	l Route Number,
	Hospi 4 hou Funer ely fill	edical	29a. Certifier 1 Certifying Phy (Check only one)	sicien: To the best of iner: On the basis of e and manner state	examination and/or	ath occurred a investigation,	it the time	, date and p nion, death	place, and occurred	d due to the cau at the time, date	se(s) and manr e and place, an	ner as st d due to	ated. the cause(s)
	To the within 2. To the Complete		29b. Signature and title of contrier	L Atte	1 PLI	29c.	License	number		290	I. Date signed (Month, l	Dey, Year)
			1 No Jung			7	Dl	9897			8-7-0	7	
C	5		30. Name and address of person white c					_		_			
		6	V. Singh, M. 31. Date filed (Month, Day, Yéär)			Pkwy	, Gi	reenb	elt,	, MD 20	0770		
	Stat Registra	- 3	31. Date filed (Month, Day, Year)	32. Registra	s Signature	hour	1.1						

			1- State Amend item15 pe	State of Maryland er FH, DOR, 8/23	/ Depa 3/0උ <i>er</i>	irtment of I	Health an <i>Death</i>	nd Mental Hy	rgiene	7 27553
			Decedent's Name (First, Middle, Last)	ыры				2. Date of De		3. Time of Death
ш	Physici		Ellen G. Beall					Aug.	10, 2007 Yes	3:50 p ^M
)	/Medic Examin		4a. Facility Name (If not institution, give stre	eet and number)		4b. City, Town,	or Location of C		4c. County of De	
			6102 Twin Point Co	ve Rd.	1	Camb	ridge		Dorch	nester
Т	Funeral		Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year Months Days		Hrs. 8. Date of Bi	av Year)	Birthplace (State or Foreign Country)
	Director		218.56.9048	93	Yrs.	WOTHITS Days	110013	Min. (Month, D. Oct. 1	8, 1 913 Wa	shington, DC
	D >		Usual Residence of Decedent 10a. State 10b. County	100 City	Town or Lo	nation				10d, Inside City Limits
	anyla eho	5								1 □ Yes 2 □ No
C	28a-1	ect	Maryland Dorcheste 10e. Street and Number	r	Ca	mbridge			10g. Citizen of What	Country?
2	with	급	6102 Twin Point Cov	o Pd			.613		US	-
3	99th	Funeral Director		. Was Decedent Ever in U.S.	13 \			? (Specify Yes or N		merican Indian,
Ö	Iter d	표	1 Never Married 2 Married	Armed Forces?	100	Yes, specify Cut	oan, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	Black, W	
2	urs a	þ	3 ☑Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	I□Yes 2⊡No	Specify:		Specify: V	Mhite
1215-0036	filed within 72 hours after deeth with the Maryland Hygiene. Inter than "naturel", or Items 23a or 28a-f ehow ont, Itte Macifical Exposition to notified a	Completed	15. Decedent's Educa (Specify only highest grade of			lent's Usual Occu kind of work done		funding	16b. Kind of Busine	
7	Far a	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	lite. L	DO NOT use retire	ed)	Working		
Z	or th	Con	12	-12		Homen	7		Own I	Home
	e d a B	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle		Jot Vnorm
<u> </u>	2 should end Men le marke aumatic	T _o	Curtis DeNeane				1		den Name N	
Ë	s 1 and 2 should f Health end Mer Item 27 le mark other traumatic		19a. Informant's Name/Relationship (Type Robert J. Beall/Gra						oer, city or rown, state Chesapeake	Boach MD
	1 and Health em 27 other tr		20a. Method of Disposition			sition (Name of	illa Tall	Date	20c. Location - City	
פֿר	m 0 .		1 ⊞Burial 2 □ Cremation 3 □ Ren	noval from State	netery, cren	natory or other pla			,	
			4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee			nCemeter	-		Brentwood,	MD
n n	permit. Departr Imports any in		Aller Hospin	1 Kenyin	1113	urran-Br 08 High	omwell St Ca	Funeral H	Home, P.A. MD 21613	
			23a Part1. Enter the disease, or complica	itions that caused the death.						Approximate
١,			shock, or heart failure. List only one Immediate Cause (Final	COCONACU	arte	di d	iscaso			Interval Between Onset and Death
	mysician /Medical		disease or condition resulting in death)	Due to (or as a conseque	_	7 9	0000			
	Examiner									
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nes of).					
	cuted nd transi	Examin	that initiated events							
Š	e exe ien a uriel-l		resulting in death) Last	Due to (or as a conseque	nce of):					
09/8	death certificate be executed e attending physicien and d for use as the buriel-transit	dical	d.							-
o ×	leath certific attending p	Med	IF FEMALE:	If you gutoome of program						
X Q	ath c attend for us	Physician/Me	in the past 12 months?	 If yes, outcome of pregnance 1 □ Live birth 2 □ Fetal dead 4 □ Pregnant at time of dead 	eath 3	Ectopic pregnanc	зу		23d. Date of Month	delivery Day Year
	the de y the a	yslc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	tn 5∟	Other (specify)				
7	uires that the dei signed by the a ld be detached f	P.	Part II. Other significant conditions contri		ing in the ur	nderlying cause g	iven in Part I.	23e. Did	tobacco use contribute	e to the cause of death?
cords,	requires that leen signed b hould be deta	d by	conjustive her	rt fulure				1 🗆	Yes 2 No 3	Probably 4 Unknown
C)	: The law require cete hes been sig page 2 should b	Completed						24a. Wa	s an 24b. Were	autopsy findings available
ě	The la ste hes page 2	E						auto	ormeid? death	a autopsy findings available to completion of cause of
VItal	certificete rector, pag	Ö	25. Was case referred to medical				26 Place of	1 ☐ Yes f Death (Check only	2/2(No 1 1)	(es 2010)
⋝ ;	ysich s cer direct	To B	examiner? 1 ☐ Yes 2 No	spital:	R/Outpatien	t 3 DOA O	hor		idence 6 Other (5	Specify)
Ö	ig Ph terth neral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	8b. Time of	28c. Inju			how injury occurred	
0	ath. or: Af	atlo	2 ☐ Accident investigation	(, 02) . 02.,	,ary		Yes 2□No	•		
DIVISION	r Affi	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location City or To	(Street and Number or own, State)	r Rural Route Number,
2	To the Hospital or Attending Physician: thin 24 hours after death To the Funarel Director: After this certifica completely filled in by the funeral director,	Cel								
	Hosp 14 hou Fune tely fi	edical	29a. Certifier (Check only one) 2 Medical Examine	ian: To the best of my knowl r: On the basis of examinatio	edge, death n and/or inv	occurred at the to vestigation, in my	time, date and popinion, death	place, and due to the occurred at the time	cause(s) and manne , date and place, and	r as stated. due to the cause(s)
	ithin (Med	29b. Signature and title of certifier	and manner stated.		29c. Licer	ise number		29d. Date signed (M	onth, Day, Year)
	F 3 F 8		9 gillui	ann		200	CIVI	.7.	00/17/	2007
			30. Name and address of person; who com	pleted cause of death (tra- 3	(Type	Print)		1 4 .		
			Eric J. Widma		3	Byrn Si	t. Ca	mbridge,	MO 2161	5
	Sta	te	31. Date filed (Month, Day, Year)	32. gistrar's Signatur	re	<i>a</i>				
	Registr	ar	AUG 1 4 ZU	II Ballion . A	αA	mark 9				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 12 per fh 9871 9-7-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death nt's Name (First, Middle, Last) 1. Deced 2. Date of Death Day **Physician** 2 0 /Medical County of Death give street and r Examiner Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 214-28-3376 XM 2□F 84 Director 3/4/1923 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Maryland Wicomico Salisbury Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30546 Bennett Road 21804 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1X Yes 251 If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Campbell Soup Co. Inspector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John A. Bradford Lizzie Lekites 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30546 Bennett Rd., Salisbury, MD 21804 Mattie Bradford/wife Baltimore, Place of Disposition (Name of cematery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place Springhill Memory Gardens 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/16/07 Hebron, MD 21. Signature of Funeral Servic Linnsee Name and Address of Facility HOIIoway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CARCINDUSA MRTASTATIC LUNG /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualts (or as a narraquenno of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the ass use 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ō Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No P.0. 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy performe rmed:/ 2[X]No certificate To the Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident 5 Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) A Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and tifle of certifier 29d. Date signed (Month, Day, Year) 00058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POBOR 1733, SALISBURY MD 21802 WARIS Year) State Registrar

State Registrar 30. Name and address of person who cop

J

Year)

NICHOLAS

ed cause of death (Item 23a) (Type, Print)

E. CAPROUST.

SALISBURY

07-06070 UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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II OINIC		- For State	tate of Maryland	Certifica	ate of	Death			Re	eg. No.	. U	- 100
Physicia		Registrar 1. Decedent's Name (First, Midd	dle,Last)						Date of Dea Month August 7,		ır	3. Time of Death 2148 hrs
e-"-al Exami		Rachel Lynae l	Baugher			p. City, Town, or	Location of		August 7,	2007 4c. County 6	of Death	
		4a. Facility Name (if not instituti Airy Hill Road	on, give street and number	r)	41	Chestertow		Deali		Kent	J D 0011	
	=	5. Social Security Number	6. Sex 7. A	ge (In yrs. last bir	thday)	If Under 1 Yea		24Hrs.	8. Date of Bir	th(MM/DD/YYYY	() 9. Bir	thplace (State or
Funeral Director	- 1	214-35-2178	1 M 2 X F	18	Yrs.	Months Day		Mın.	10/25		Foreig	gn puntry) <u>DE</u>
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Maryland 28a-f show any d at once.				Elkto								1 Yes 2 X No
yland a-f sh	흸	MD Cec:	T.T.	EIKLO	·11	10f. Zip Code			1	0g. Citizen of W	hat Cou	intry?
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Director	120 Jones Cha	pel Rd.			21921			8 19	USA		
with the ss 23a e noti		11. Marital Status	12. Was Decede		13. Was	Decedent of His	spanic Ong	in? (Spe	cify Yes or No	14. Race	e - Ame	rican Indian, Black,
eath r	Funeral	1 X Never Married 2	Married Armed Forces	s? 2 X No		es, specify Cubar		Puerto P	(icari, etc.)			7
after call, or	by F		livorced If Yes, Give Year or Dates:			Yes 2 X No				Specify:		√hite
5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examiner.	pa pa	15. Decedent's Education (Sp		, ,	Decedent during mo	st of working life	ition (Give k e. DO N OT i	and of wa use retire	ork done ed)	16b. Kind of B	usiness	/industry
36 n 72 h nan "1	Completed	Elementary/Secondary (0-12	2) College (1-4 o	ir 5+)	Stu	dent				Stu	dent	Ė
withi withi giene. her th	E	17. Father's Name (First, Midd	le Last)				18.Mother	s Name	(First, Middle,	Maiden Surnam		
r15- e filed al Hy ceó ot nt, thu	Be C	Daniel Thom							Faulkne			
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiest 27 is markeo other than "natural", or items 23a or 28a-f she amatic event, the Medical Examiner must be notified at once	2	19a. Informant's Name/Relation		19						mber, City or To		te, Zip Code)
nore, MD 21215-003 signs 1 and 2 should be filed within the of health and Mental Hygiene. T: If item 27 is markee other the other traumatic event, the Med		Daniel Baug	her/Father					. Kd	Date	n,MD 21		or Town, State
re, h s 1 and f Healtl if item er trau		20a. Method of Disposition 1 X Bunal 2 Cremati	ion 3 Removal from		of Dispos atory or oth	ition (Name of center place)	emetery,		Date			
more Pages 1 nent of F ant: If i		4 Donation 5 Other	Specify:	Rose	Bank	Cemeter	-v	08/	2/07	Rising e en ei	Sui	n,MD
Baltimore, permit. Pages l at Department of Hes Important: If ite injury or other tr		21. Signature of Funeral Servi	ce Licensee		22. N	lame and Addres	ss of Facility	heet	ows, me	n, MD 21	n α 620	newnam
		25a. Part I. Enter the disease,	or complications that caus	ed the death. Do r								Approximate Interval
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aminer		Immediate Cause (Final disea or condition resulting in death			nai mjor	les and mon	ipie irijoi	163				
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Box 68760, e death certificate be execut the attending physician and ed for use as the burial - trai	/Me	IF FEMALE: 23b. Was decedent pregnant in	- the	come of pregnanc		4-1 de-sh 3	Ectopi	c pregna	ncv	23d. Date Month	of deliv	ery Day Year
certificanting	sician/	past 12 months?	4 Pregnan	t at time of death	-	etal death 3 ther (Specify)	Lotopi	o progra				
Box 687 e death certific the attending f ed for use as th	ysi	1 Yes 2 No 9 🗸	0								1-711	At the serves of dooth?
P.O. s that the gned by t	y Phy	Part II. Other significant con	ditions contributing to de	eath but not result	ting in the	underlying cause	e given in P	art I.				to the cause of death? robably 4 Unknown
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ords, w requir s been s	# #								aut	opsy formed?	prior t death	o completion of cause of
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Division of Vital Records, tal or Attending Physician: The law requires after death. In a Director: After this certificate has been is led in by the funeral director, page 2 should it.	BeC	25. Was case referred to med examiner?	t to a situation of				Other		per	Residence 6		h Coope
of Vit ing Physica After this o		1 ✓ Yes 2 No			/Outpatien		njury at Wor		ng Home 5	Residence of		ner: Scene
n of ling Ph After t	Ë	27. Manner of Death 1 Natural 5	28a. Date of FOUND:	Injury 289 Pay, Year) FO	b. Time of DUND:	· ·	Yes 2 ✓		Subject pa	assenger in v	ehicle	e in vehicular
VISIOR or Attend after death Director:	ati	2 Accident	Aug 7, 200		141 hrs				accident	(Street and Nur	mber or	Rural Route Number, City
Ivis lor A after Dire	Certification:	3 Suicide 6 0	ould not be	t injury - At nome Local Street	e, tariii, Su e	set, factory, office	e pallating, v	510.	or Towr			
ospita hours			- Physician: To the best of	of my knowledge	death occi	irred at the time.	date and p	lace, and	due to the ca	ause(s) and man	ner as s	stated.
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. After this certificate has been signed by the attending prominetely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only one) 2 Medical I	Examiner: On the basis of	examination and/o	or investiga	ation, in my opin	ion, death o	ccurred	at the time, da	te and place, an	d due to	the cause(s)
To T	₩ W	29b. Signature and title of ce	and manner star rtifler	ied		29c. Lice	ense numbe	er		29d. Date s	igned (Month, Day, Year)
		7/1	1/1/2	/ Tn.		0.0	C.M.E.	OCME		August 8	3, 200	7
2		30. Name and address of per	son who completed cause	of death (Item 23								
- 2		Theodore M. King,		t Medical Exa	miner	111 Penn :	Street, B	altimo	re, MD 212	201		
	State			ar's Signature		Boutt o						
Regi	stra	AUG AUG	1 0 2007	All Annual of	9							
DHMH 17 Rev 1	/2001			(ORIGIÑ.	AL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended #5 1 - For State Registrar 08/14/07, T.M., Kent Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2100 PM August Jurham 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner River Hospital enter en Birthplace (State or Foreign Country)
 MD Security Number 9 If Under 1 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🛣 F Months Director 220-12-1595 85 10/19/21 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anne. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Kent 1 Nes 2 No Chestertown Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 Morgnec Rd. Apt 102 21620 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White Specify. ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leonard A. Durham Margaret Anthony 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Price / Daughter 7992 Aldan Dr. Chestertown, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. 08/13/07 Hurlock, MD 4 Donation 5 Other (Specify) uneral Service Li 22. Name and Address of Facility Fellows, Helfenbein & Newnam 21. Signature 370 Cypress St. Millington 2165 PO Box 270 flours 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ho peratun **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown Month Year Day 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1☐ Yes 2 1 No certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes, 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 🗌 No neral Director: / 2 ☐ Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I 29b. Signature 29d. Date signed (Month, Day, Year) 50060301 12 Completed cause of death (Item 23a) (Types Print) 30. Name and address of perso

DHMH 17 Rev 1/2001

State Registrar

(25)

AMEN

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 11:06 AM Elizabeth Ann Barry 2007 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Hospital of Cecil County E1kton Ceci1 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2XXF Months 145-34-5897 Director 66 5, 1941 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Exami, or most be notified at 1 X Yes 2 □ No Director Maryland Cecil North East 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 520 South Main Street, Apt. 203 21901 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) filed withi Hygiene. 12 Child Caregiver Day Care 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) should be f nd Mental I John Trokan Ann Hanik 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21901 19a. Informant's Name/Relationship (Type, Print) 1 and 2 st if Health ar William J. Barry / Husband 520 South Main Street, Apt. 203, North East, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Important: If ite
ony injury or ot August 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Mayerdale Crematory | 13, 2007 4 Donation 5 Other (Specify) Newark, Delaware 22. Name and Address of Facility Crouch Funeral Home 21. Signature of Fund 127 South Main Street, North East, Maryland 21901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Immediate Cause (Final EPSIS unknown Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury Due to (or as a consecuence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No Dav 4 Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 → 10 24a. Was an this certificate has al director, page 2 1 Yes 2 No After this certific funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 SER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 SNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by within 24 hours aftar of To the Funeral Directorpletely filled in by 4 Homicide ō To the Hospital 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year)
ANSULT 12, 2007 29b. Signature and title of certifier 29c. License number D51511 $\sqrt{\sqrt{2}}$ 5 Med ELKIN, MD mpleted cause of death (Item 23a) (Type, Print) 30. Name and address of person 106 BOW MD JBEAMA AJYOK 1112 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 4 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last)

7. Age (In vrs. last birthday)

79

Yrs.

10c. City, Town or Location

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Hours

CENTREVILLE

Days

Physician /Medical Examiner

Funeral

SIDNEY ALLEN BRANHAM

5. Social Security Number

216-20-3992

10a, State

Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

1 X M 2 □ F

143 WINDY ACRES FARM LANE

10b. County

Director r 28a-f show notified at ber "natural", or items 23a edical Examiner must b raumatic event, the Medical

Director MARYLAND QUEEN ANNE'S CENTREVILLE 10f. Zip Code 10e. Street and Number 143 WINDY ACRES FARM LANE 21617 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after Hygiene. 1 MYes 2 □ No If Yes, Give Year or Dates: **1944–1946** 1 Never Married 2 Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event". Elementary/Secondary (0-12) College (1-4or 5+) CRANE OPERATOR 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MINNIE V. JOHNS JAMES BENNETT BRANHAM 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) STEPHANIE BRANHAM/WIFE 143 WINDY ACRES FARM LANE, CENTREVILLE, MARYLAND 21617 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition AUGUST 14 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CHESAPEAKE CREMATION 2007 21. Sign re of Fary ral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A.
408 SOUTH LIBERTY ST, CENTREVILLE, MARYLAND 21617 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. puluman Immediate Cause (Final disease or condition resulting in death) Physician CARDIO /Medical Due to (or as a consequence of): Examiner OF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a o nsequence of): Physician/Medical Examiner The law requires that the death certificate be executed Due to (or as a consequence of): as the burial-tran Division or Vital Records, P.O. Box 68760, physician IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown ate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by autopsy performe certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 No this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No r death. I hours after death.

uneral Director: A

ely filled in by the fu 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Vithin 24 hours and To the Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29b. Signature and title of certifie D23889 :ff ompleted cause of de (Item 23a) (Type, Print) 30. Name and ordress of per 223 Hogh Street, (Hertentown, Wed 21620 AnnitisAL TR. H.D 32. Registrar's Signature 31. Date filed (Month, Day,

Alexand St.

CHICINAL

8:53 AM AUGUST 13 2007 4c. County of Death **OUEEN ANNE'S** 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, SEPTEMBER 13, 1927 VIRGINIA 10d. Inside City Limits 1 ☐ Yes 2 X No 10g. Citizen of What Country? UNITED STATES 14. Race - American Indian Black, White, etc. Specify: WHITE 16b. Kind of Business/Industry CONSTRUCTION 20c. Location - City or Town, State STEVENSVILLE, MARYLAND 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 ■ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year)

3. Time of Death

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Chandler **Physician** Aleah Denise 350 2007 August /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Peninsula Regional Medical Center Alisbury Wickmick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months Min. 1 □ M 2**X** n/a Director 40 Maryland 8/9/2007 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director Salisbury Wicomico Maryland 10f. Zip Code 21801 10e. Street and Number 10g. Citizen of What Country? USA 1023C Marine Road items 23a permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other any injury or other to the state of the Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No If Yes, Give 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1X Never Married 2 ☐ Married African/ 1 ☐ Yes 2 No Specify. ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) n/a n/a n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tara Christopher Isaac Chandler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1023C Marine Rd., Salisbury, MD 21801 Tara Christopher/mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/13/07 Salisbury, MD Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 CFSP 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 700 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Extreme /Medical Due to (or as a consequen of) Examiner Sequentially list conditions, large cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2□ No 2 X No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ this 28a. Date of Injury (Month, Day Year) To the Funeral Director: After th completely filled in by the funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 ☐ Pending investigation 2 ☐ Accident М 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

OM

State Registrar 30. Name and ad

31. Date filed (Month, Ray Kear) 4 2007 32. Restrar's Signature

s of person who completed cause of death (Item 23a) (Type, Print)

100 East

Carroll Street

21801

Salisbu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear Brian 1207 PM August akon 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs: Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 149-44-8324 54 May 2, 1953 New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Ceci1 E1kton 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 133 Willow Oak Court 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Information Technology Spec. U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hershel Clifton Eleanor Marecki 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maureen Clifton / Wife 133 Willow Oak Court, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State August 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Mayerdale Crematory 17, 2007 4 □ Donation 5 □ Other (Specify)

21. Signatu of when ervic ic. v e Newark, Delaware Crouch Funeral Home 127 South Main Street, North East, Maryland21901 Approximate Interval Between Onset and Death 23å. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final iver. week disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 9□Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2010 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Appatient Manner of eath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 1 Natural

Physician /Medical **Examiner** Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if I flem 27 is marked other than "natural" ~ ... any hipty or other traumatic event.

The law requires that the death certificate be executed attending physician and for use as the burial-trar signed I certificate or Attending Physician: this After thi funeral

Division or Vital Records, P.O. Box 68760,

IF FEMALE:

Physician/Medical

Completed by

Be

2

Certification:

Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 ☐ Yes

5 Pending investigation 6 Could not be

determined

(Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

AUG 1 4 2007

29d. Date signed (Month, Day, Year)

medical Doctor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe Street Baltimore Margard 21287 Johns Hopkins Hospital Dezern The 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State

ours after death.
neral Director; /
filled in by the fi

within 24 hours a To the Funeral 6 To the Hospital

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** AUGUST ¹2^y3 20⁰6¹7 TIMOTHY **JARVIS** DAGGETT 2:16 pm /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Chester River Hospital Chestertown Kent If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year)
Nov 17 1944 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2□ F 220-40-7943 62 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ont if item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits er than "natural", or items 23a or 28a-f show, the Medical Examiner must be notified at 1 ☐ Yes 2 TXNo Director MD Kent Worton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 24405 Waterview Dr. 21678 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1X Yes 2 No 1969 If Yes, Give Year or Dates: -1970 1

☐ Never Married 2

☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗷 No Specify: þ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Town of Middletown Purchasing Manager 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy Tromblee Parker H. Daggett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau (wife) Leslie Daggett 24405 Waterview Dr. Worton, MD. 21678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 8/24/07 Kent Cremation Smyrna, DE. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign fly of Feb. Licensee 22. Name and Address of Facility Home of Stephen L. Schaech St. Galena, MD. 21635 Galena Funeral 118 West Cross M00510 Approximate Interval Between Onset and Death disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrost, adjure. List only one cause on each line. 23a. Part1 Enter the shock, or heart; Immediate Cause inal disease or condit n resulting in death) Comus **Physician** 04 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an has e 2 autopsy perform certificate 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2[7No 1 Inpatient 2 ER/Outpatient 3 DOA P this After thi 27. Mayner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the f 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Dav. Year) 286. Signature and title of certifie 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patrick Shanahan, M.D. 120 Speer Rd. Chestertown, MD. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 8 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

ich	ael Allen l	Den	1-	State of Maryland / Department of Health and Mental hy For State Certificate of Death	/giene _{Reg. 1}	No	7 2756
	Physic		1	edistrar . Decedent's Name (First, Middle,Last) MTCHAEL ALLEN DENNIS	2. Date of Death Month Da August 1, 20	ay Year	3. Time of Death 1248 hrs
ilec	dical Exar	mın		a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Deat	n .
				University of Maryland Medical Center Baltimore Social Security Number 16 Sex 17 Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Birth (MM/DD/YYYY) 9. Bi	rthplace (State or Foreign
	Funera Directo			222-60-4006 1XM 2F 30 Yrs. Months Days Hours Min.	_	C	ountry)
	d how any	انو	1	DE KENT FELTON			10d. Inside City Limits 1 Yes 2 No
	e Maryland or 28a-f show	notified at once.	Director	Oe. Street and Number 4165 HILLS MARKET RD. 10f. Zip Code 19943	10g.	Citizen of What Co USA	untry?
	215-0036 be filed within 72 hours after death with the Maryland nial Hygiene. rked other than "natural", or items 23a or 28a-f sh	ust be not	ᇹ	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Sp. 14 Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	White, etc.	rican Indian, Black,
	ours after d	miner	ᅪ	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Lisual Occupation (Give kind of viging most of working life. DO NOT use retired.	work done 1	Specify: WH	
	21215-0036 Auld be filed within 72 h Mental Hygiene. marked other than "n	the Medicaí Exa	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) 10 ROOFER	100	CONSTRUCT	ION
	e filed with tal Hygiene ked other t	šΙ	Be C	MICHAEL HOWELL PATTY	DENNIS		
	Man Me	5		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or			
	ore, MD es 1 and 2 sho of Health and If item 27 is	rauma	1	MICHAEL HOWELL 8136 LOMA DEL NORTE N 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 2	UERQUE, N 20c. Location - City	or Town, State
	Baltimore, permit Pages I a Department of He Important: If ite	or other traumatic		1 Burial 2 X Cremation 3 Removal from State CAPITOL CREMATORY 4 Donation 5 Other Specify:	4-07	DOVER, D	
	Baltimo permit Page Department or Important:	injury	- 1	Henre on Short 119 NW FRONT ST.,	MILFORD,	T FUNERAL DE 19963	
	Physicia			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death
	/Medic 'xamin	_		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			Boain
		ı		Sequentially list conditions,			-
			Examiner	if any, leading to immediate cause. Enter Universing Cause (Disease or injury that initiated			
	ecuted	- transit		events resulting in death) Last Due to (or as a consequence or):			
	30, te be exe tysician	burial	Medical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliv	rery
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been staned by the attending physician and	completely filled in by the funeral director, page 2 should be detached for use as the	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregregation of the past 12 months? 4 Pregnant at time of death 5 Other (Specify)	nancy	Month	Day Year
	D. Bc	ached fo	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?
	b, P.(d be del	ed by		1Yes - 24a. Was a		robably 4 Unknown autopsy findings available
	aw requ	2 shoul	Completed		autops perforr	y prior ned? death	to completion of cause of
	Rec: The lifeate l	r, page	S	25. Was case referred to medical 26.Place of Death (Chec	1 Yes 2	No 1 🗸	Yes 2 No
	Vital ysician	directo	To Be	Othory			ther:
	Division of Vital Records, P.O. tal or Attending Physician: The law requires that the standard earth. The standard of the physician of the standard physician and the physician of the physician	he funeral	tion: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury Jul 29, 2007 28b. Time of Injury 0130 hrs 1 Yes 2 ✔ No	Passenger o		way and overturned
	Division Attentions of the Attention	lled in by t	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Major Road	28f. Location (S or Town, St Blanchard Rd	treet and Number of ate) & Epworth Churc	Rural Route Number, City n Rd, Greenwood, DE
	To the Hospi within 24 hou	mpletely fi	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the cause d at the time, date a	and place, and due	o the cause(s)
4	F W F	.03	Me	29b. Signature and title of certifier O.C.M.E.		29d. Date signed August 2, 200	
				30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltime	ore, MD 21201		
			tate	31. Date filed (Month, Day, Year) 2 2007 32. Registrar's Signature			
	Re	OIS	trar	Und to Free American			

ORIGINAL

27:61

		1 - State Registrar	State of Maryland / D	Certificate of L	Death	Re	g. No.		
		1. Decedent's Name (First, Middle, Last)			2. Date of Death		Year	3. Time of Death
Physic		Thomas William	Dorsey, Jr			August	Day 13 20	07	6:00 A
/Medi		4a. Facility Name (If not institution, give			Location of Death			y of Death	10.00
Exami	ner						36		
		12701 Lewisdale Ro		Clarksbu		8. Date of Birth	Montg		olace (State or Foreig
Funeral	_	5. Social Security Number 6. Se	X14 2005	Yrs. Months Days	Hours Min.	(Month, Day,	Year)	Cour	ntry)
Director		219-20-2748	80	115.		Dec. 2,	1926_	Mary Mary	Land
p ,		Usual Residence of Decedent	10.00				·	1.	10d. Inside City Limit
how I	١.	10a. State 10b. County	10c. City, Towr	n or Location					
Ma -	ō	Maryland Montgomer	cy Clarksb	ure					1 ☐ Yes 2 🛣 N
158 E	Director	10e. Street and Number	102=2002	10f. Zip Code		16	og. Citizen of	What Cour	ntry?
With the second		10701 7 4 1 1 7		00071			a 4		
a within 72 hours after deeth with the Maryland jiene. rithen "naturel", or teme 23a or 28a-f show the Madical Exacilrar roust be notified at	Funerai	12701 Lewisdale Ro	12. Was Decedent Ever in U.S.	20871	annais Orinia? (Ca		SA 14 Ba	ice - Americ	can Indian
or de	i i	11. Marital Status	Armed Forces?	13. Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		ack, White,	
afte o	F	1 Never Married 2 X Married	1 X Yes 2 No If Yes, Give 10 F0 F2	1 Yes 2 X No	Specify:		Speci	ify: ¬¬	
ours	d by	3 Widowed 4 Divorced	Year or Dates: 1950-52					Bla	
72 h	Completed	15. Decedent's Edi (Specify only highest grad		Decedent's Usual Occupa	ation	ana	16b. Kind of I	Business/In	dustry
	pie	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done of life. DO NOT use retired)	M	lontgor	nery (County
The British	E	7		ensed Plumb	er	F	ublic	Schoo	ols
e filed within al Hygiene. I other then vent, the M	O	17. Father's Name (First, Middle, Last)				e (First, Middle, N			
Pages 1 end 2 should be filed vinent of Health and Mental Hygie sant: if item 27 ts marked other fury or other traumatic event, III.	00						- 1		
Me Me	ပ	Thomas William Do				lizabeth_			
and		19a. Informant's Name/Relationship (7)	ype, Print) 19b.	. Mailing Address (Street a	and Number or Ru	ral Route Number,	City or Town	n, State, Zij	o Code)
alth 27		Thomas W. Dorsey,	III 12	729 Lewisda	le Road,	Clarksbu	irg, Ma	arylan	nd 20871
E E E		20a. Method of Disposition	20b. Place of	Disposition (Name of		Date	20c. Location	· City or To	own, State
or it		1 X Burial 2 ☐ Cremation 3 ☐	Hemoval from State	ry, crematory or other plac	10/1/	/2007	1 0		
ant an		4 ☐ Donation 5 ☐ Other (Specify	Pleasar	nt Grove Chr					
permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service Licens	600	22. Name and Addres					ineral Hor
88 E 2 8		May M.	Auc	26401 Ridge	Road, D	amascus,	Mary1	.and	20872
	-	23a. Part1. Enter the disease, or comp shock, or hear failure. List only	lications that caused the death. Do r	not enter the mode of dyin	g, such as cardiac	or respiratory arre	est,		Approximate
	1								Interval Between Onset and Death
Physician		Immediate Came (inal disease or condition	Emp144	SEMA					3 YEARS
/Medical		resulting in death)	Due to (or as a consequence	of):					
Examiner									
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	 Due to (or as a nonsequence) 	ofi					-
sit ed	Ē	cause Enter Underlying							
ecut ind tran		Cause (Disease or injury							
	(an	that initiated events	C. Due to fee a consequence	-A).					
en a	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of	of):					
e be exe /sicien a e burial-	cai Exan	that initiated events	c. Due to (or as a consequence of	of):					
ficate be executed physicien and is the burial-transit	dicai	that initiated events	Due to (or as a consequence of	of):					
certificate be ext ding physicien a se as the burial-	edical	resulting in death) Last	d	of):			23d 0	late of delive	(ADV
ath certificate be exitending physicien a or use as the buriat-	edical	IF FEMALE: 23b. Was decedent pregnant	d	3 □Ectopic pregnancy				Date of deliv	rery Day Year
s death certificate be exe ne attending physicien a ed for use as the burial∹	edical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	d						-
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aw requires that the death certifi is been signed by the attending 2 should be detached for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		24a. Was a autops perforr	oacco use co es 2 □ No n 24b y ned?	ntribute to 1 3 Prol . Were autreprior to codeath?	the cause of death? bably 4 Unknown opsy findings availal ompletion of cause of
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ling Physician: The law requires that the death certifi After this certificate has been signed by the attending uneral director, page 2 should be delached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions	d	3 Ectopic pregnancy 5 Other (specify) In the underlying cause give Substitution and DOA Other Time of 28c. Injury	en in Part I. 26. Place of Deaer: 4 □ Nursing H	24a. Was a autops perform 1 Yes 24 th Check only on	opacco use co os 2 \(\text{No} \) on 24b on	ntribute to t 3 Prof . Were autr prior to co death? 1 Yes	the cause of death? bably 4 Unknown opsy findings availal ompletion of cause of
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or Attending Physician: The law requires that the death certifier death, irretor: After this certificate has been signed by the attending by the funeral director, page 2 should be delached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnancy 1	3 Ectopic pregnancy 5 Other (specify) In the underlying cause given It patient 3 DOA Other Ot	26. Place of Dea er: 4 □ Nursing H y at k? Yes 2 □ No ne, date and place pinion, death occu	24a. Was a autops perform 1 Yes 2 th Check only on ome 5 \times Reside 28d. Describe how 28f. Location (St. City or Town, and due to the carried at the time, d.	opacco use co	ntribute to 1 3 Prol Were autr prior to cc death? 1 Yes ther (Special or Run manner as see, and due to	the cause of death? bably 4 □Unknow opsy findings availat ompletion of cause of 2 □ No fry) ral Route Number, stated. to the cause(s)
itending Physician: The law requires that the death certifi death. Stor: After this certificate has been signed by the attending ∤ the funeral director, page 2 should be detached for use as	edical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnancy 1	3 Ectopic pregnancy 5 Other (specify) In the underlying cause give Stratient 3 DOA Cth Time of Jesc. Injury Wor 1 Itm, street, factory, office a, death occurred at the tim td/or investigation, in my of 1 29c. Licens	26. Place of Dea er: 4 □ Nursing H y at k? Yes 2 □ No ne, date and place pinion, death occu	24a. Was a autops perform 1 Ves 2 th Check only on ome 5 \$\infty\$ Reside 28d. Describe ho 28f. Location (St. City or Town, and due to the corred at the time, d.	opacco use co	Anoth Tribute to 1 Tribute t	baby Year the cause of death? bably 4 □Unknow oppy findings availat ompletion of cause of 2 □ No al Route Number, stated, to the cause(s)
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	1	For State Registrer Certificate C	of Health and North	Reg.	2011 11 / 191
Physician /Medical		Decedent's Name (First, Middle, Last) Donald Cale Drury		August	Day Year 7:05
Examiner Funeral		113 West Salisbury Street Will Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye	iamsport amsport amsport Bar If Under 24 Hrs. Bays Hours Min.	8. Date of Birth (Month, Day, Ye	4c. County of Death Washington 9. Birthplace (State or Country)
Director	U	220-30-9914	ays (10015 Nill)	Dec.31,19	934 Mary Land 10d. Inside City
oeam with the Maryland ms 23a or 28a-f show frought be notified at neral Director	1	Maryland Washington Williamsport Oe. Street and Number 10f. Zip Cod	de	10g.	1 XYes 2
Fu Fig.			795 of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Specify:	pecify Yes or No- Rican, etc.)	USA 14. Race - American Indian, Black, White, etc. Specify: White
ed within 72 hours atter ygiene. Set than *natural; or ite ite. It, it a Medical Examinat, Completed by Fur		15 Decedent's Education 16a Decedent's Usual Oc	lone during most of won etired)	king	b. Kind of Business/Industry Education
12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, tra Mer		7. Father's Name (First, Middle, Last) Unknown	18. Mother's Nam	ne (First, Middle, Mar Louise Cor	by
Pages 1 and 2 sho nent of Health and N nt: If tem 27 Is ma iry or other trauma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Str Vicki Bender - Daughter 15920 Drury 10a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify) Riverview Cemeter	Lane Wil	liamsport,	ity or Town, State, Zip Code) MD 21795 c. Location - City or Town, State Iliamsport, Mary I
permit. Pages 1 Department of H Important: If ite any injury or ott		21. Signal re of Funeral Scott	ddress of Facility Osl	porne Fune	eral Home,P.A.
hysician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.			t, Approximate Interval Betwonset and D
iste be executed the burial-transit and the burial-transit	Lyaning	1 0/1			Approximate Interval Between and O
cate be executed physician and the burial-transit the burial-transit dical Examiner	carcal Evanime	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, frank, leading to intrinducte cause. Enter Underlying Cause (Disease or injury that initiated events C.	f dying, such as cardiac		23d. Date of delivery Month Day Y
es that the death certificate be executed to the attending physician and be detached for use as the burial-transit by Physician/Medical Examiner	by ruysicial medical Examines	Instruction in death) a. Due to (or as a consequence of): b. Due to (or as a consequence of): b. Due to (or as a consequence of): cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No No No No 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Personant at time of death 5 Other (specific pregnant	f dying, such as cardiac	or respiratory arrest	23d. Date of delivery Month Day Y
The law requires that the death certificate be executed to the law requires that the death certificate by the attending physician and page 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner	Completed by Thysical Phanista	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	nancy fy) se given in Part I.	23e. Did tobal 1 Yes 24a. Was an autopry performs	23d. Date of delivery Month Day Y cco use contribute to the cause of de 2 No. 3 Probably 4 U 24b. Were autopsy findings a prior to completion of ca death? 1 Yes 2 No.
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		State of Maryland /	Depa <i>Cen</i>	rtment of Hea	lth and M ath		giene [] [] []	7 27565
200	76	Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Dea	3. Time of Death			
Physicia	an 🤅	Anna Julia Fishpaw				Aug.	23, 2007 ea	5:20 AM
/Medic Examin	- 46	4a. Facility Name (If not institution, give street and number) 4730 Alesia Road		4b. City, Town, or Loc Manches			4c. County of De	
Funeral Director		5. Social Security Number 6. Sex $1 \square M$ 2 \cancel{M} F 7. Age (In yrs. last b.	irthday) Yrs.	If Under 1 Year If U Months Days H	Under 24 Hrs. ours Min.	8. Date of Birt (Month, Da Aug • 6	y, Year) 9. E 1940 Ma	Birthplace (State or Foreign Country) Aryland
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with the or 24	Funeral Director	10e. Street and Number 4730 Alesia Road		10f. Zip Code 21102			10g. Citizen of What U.S.A	
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Dallinore, permit. Pages 1 am Department of Healt Importent: If item 2 any injury or other once.		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place cemet	of Disposery, crem	sition (Name of Datory or other place) United t Cemetery	l Aug.	25,	20c. Location - City	
Datification Department of property of particular of particular of particular of particular or of particula		'4 □Donation 5 □Other (Specify) Metho	dis	t Cemetery	2007		Sparks,	Mortuary, Inc
Dermi Depart Impo		Makel W. Merrane	2	4 Second	St., 1	New Fr	eedom, PA	17349
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. BOX 68/ death certificate e attending phys id for use as the	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			-		23d. Date of	delivery
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DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, str	eet, factory, office	A		(Street and Number o wn, State)	r Rural Route Number,
Hospitel or 24 hours afte Funerel Dir etely filled in	edical C	29a. Certifier 1 Certifying Physician: To the best of my knowled (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	lge, deatl and/or in	n occurred at the time, vestigation, in my opini	date and place, on, death occur	and due to the red at the time,	cause(s) and manne date and place, and	or as stated. due to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier		29c License o	303	1	29d, Date sign of (N	Sonth, Jay, Year)
15		30 Name and address of pron who completed cause of death (Item 23)	55 C	Bouth Cento	nSt. M	Vestmi	nstei m	D 21157
Sta Regist	ate	31 Date filed (Month, Day, Year) 32. Registrar's Signature						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year Physician 10 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner mb Wicomizo 7. Age (In yrs. last birthday)
Yrs. If Under Hours Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 1 M 2 F Months -20-8263 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Nes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 21613 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronics Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be liam Vera ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Burtonsville, MD. Birming 5012 rus arrow 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State 8/16/07 taylors Island, 4 □ Donation 5 □ Other (Specify) Cemeteri 22. Name and Advess of Facility
11 to Mry Funeral Home, P. A.
510 Washing ton St. Cambridg 21. Signature of Funeral Service Licensee ال MD.21613 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** BMENTIA 5 TAGE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner URINARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner KXPRRTRNS100 Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 /No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 446 24a Was an was autopsy performed? 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: **N**ipatient 2000 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes Medical Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending nhysician and Division or Vital Records, P.O. Box 68760,

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0053410 -07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1737 SALISBUR BOX 2180 HOSPICE

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) August 8, Day 2007 17:20 M **Physician** Shirley Esther Fuzzell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis Sunrise Assisted Living If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday 5. Social Security Number 6. Sex **Funeral** Days 1 □ M 2 🖸 F 82 Aug.13,1924 Arkansas 446-14-2333 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location the Maryland 10b. County 28a-f show 1 VYes 2 □ No permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified a once. Anne Arundel Annapolis Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21401 1703 Mansion Ridge Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 □ No Saltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16h Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Esther Catherine Sherry James Wallace P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1703 Mansion Ridge Road, Annapolis, MD 21401 Roderick Isler / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation Little Rock, Arkansas 8/15/07 4□Donation 5 NOther (Specify) Entombment Calvary Cemetery 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. of Funeral Service Lice 147 Duke of Gloucester St., Annapolis, MD 21401 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 0 cand Due to for as a consequence of) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
9 Funeral Director: After this certificate has been signed by the attending physician and physician and the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, as attending properties for use as IF FEMALE 23c. If ves. outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐Live birth 2 ☐ Fetal death Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 1 ☐ Yes 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Hospital 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 | Yes 2 → 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred funeral 27. Manner of Death 1 Natural 28a. Date of Injury Certification: (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) upletely filled in by determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Registrar

within 24

31. Date filed (Month, Day, Year) AUG 1 3 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr.

29b. Signature and title of certifier

Ъ



29c. License number

Richard Bernstein

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Emor **Physician** von Gersdorff Gift 10:05 AM 19UST 19 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7/31/1965 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Min. 1 ☐ M 2 🗓 F Months Days 42 VIRGINIA Director 223-25-9077 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Director BERKELEY FALLING WATERS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 86 MARIETTA LANE 25419 USA by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural"; or iter any Injury or other traumatic event, the Medical Examin 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) CITICORP Elementary/Secondary (0-12) College (1-4or 5+) ASSISTANT VP UNIT MANAGER (CREDIT CARD CO.) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PHYLLIS M. DARDIS RICHARD D. CARROLL ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 86 MARIETTA LANE, FALLING WATERS, WV 25419 JOSEPH E. GIFT/SPOUSE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State August 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State SMITHSBURG CREMATORY 23, 2007 SMITHSBURG, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, P.O. BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Biletal Breast

Du to (or as a consequence of): Immediate Cause (Final disease or condition resulting in death) nt lammatary **Physician** /Medical moonth Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown te has teen signed I age 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XV0 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has autopsy perform 2 No or Attending Physician: certifica director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Propatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ² 1 Yes 2 10 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide the Hospital within 24 hours a

To the Funeral I

completely filled 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar 29b. Signature and title of certifier

8"2007

31. Date filed (Month C

erson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

M

29c. License number

29d. Date signed (Month. Dav. Year)

agenatown,

07-06409								
Judy W Gromis								

idy W Gromis		- For State	ite of Maryl	land / Depa <i>Cer</i>	rtment of rtificate of			Menta	al Hyg		g. No.		7 2757
Physiciar	_	Registrar 1. Decedent's Name (First, Middle	,Last)						2	. Date of Death Month	1	Year	3. Time of Death
ledical Examin		Judy Western								August 18,	2007		2108 hrs
		4a. Facility Name (if not institution	, give street and r	number)		b. City, To					4c. Cour	nty of Death	
./	4	St. Mary's Hosp ED	C. Pay	7 Ago (In uso I		Lexing If Under		If Under		8. Date of Birtl			thplace (State or
Funeral Director			6. Sex	7. Age (In yrs. I		Months		Hours	Min.		`	Foreig	n North
	ŀ	220-56-6741 Usual Residence of Decedent	1 M 2 X F	56	Yrs.					03/04/	1951		^{untry} Carolina
any		10a. State 10b. County		10c. City,	Town or Locati	on							10d. Inside City Limits
*		Maryland St. Ma	rv's	Lex	ington	Park							1 Yes 2 X No
daryland 28a-f show 1 at once.		10e. Street and Number	- 			10f. Zip (Code	-		. 10	g. Citizen of	f What Cou	ntry?
the M a or 2	5	20231 Hermanvil	le Road			206	53			- · [Inited	Stat	es
with ms 23	Funeral	11. Marital Status		ecedent Ever in U Forces?			t of Hispa			cify Yes or No-	14. R		ican Indian, Black,
death or ite	Ş۱	1 Never Married 2 X Ma	1 Yes	2 X No					Fuello IX	:			
s after			or Dates:			Yes 2						of Business/	
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hin 72 e. Chan dical	읣	12	Conlege	(1-4-01-01)	Graphi	ic Ar	tiet				GOVE	romen	t Contractor
5-0036 led within 72 hours at Hygiene. Other than "natural the Medical Examin	Completed	17. Father's Name (First, Middle,	Last)		orapii			B.Mother's	Name (I	First, Middle, N			e ooneraceor
21215-0056 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	a B	James Thomas Wh								Fields			
Baltimore, MD 21215-0056 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23n or 28n-f she injury or other traumatic event, the Medical Examiner must be notified at once	₽Г	19a. Informant's Name/Relationsh					,			ral Route Num			
MC 2 s alth au 27 raums	-	Terry Lee Gromi 20a. Method of Disposition	.s/ Husba		20231 Place of Dispos					, Lexin			MD 20653 Town, State
or He of He tu	1	1 Burial 2 X Cremation	3 Removal		crematory or oth		e or cerre	etery,		Date	200. L 00at		Town, State
lim Pag ment tant:	L	4 Donation 5 Other Sp	ecify:	Br	insfield	I-Ech	ols (Cre.	08/2	23/2007	Charl	otte	Hall, MD
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/Medical	1	failure. List only one cause	on each line.										Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)		ac arrhythr s a consequence o					_				
		Sequentially list conditions,	b										
	miner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	s a consequence of	of):								
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Box 68760, c death certificate be the attending physic of for use as the bur	<u>ا</u>	IF FEMALE: 23b. Was decedent pregnant in th		s, outcome of preg e birth		tal death	3	Ectopic	pregnan	icv	23d. Da Mon	ite of deliver	ry Day Year
x 6	sician/M	past 12 months?	4 Pre	egnant at time of d	ooth -	her (Spec	ify)						
Boy e deatl the att	ᇍ	1 Yes 2 ✔ No 9 Unk	9	known									
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fVi Physi er this	္ျ	1 Yes 2 No 27. Manner of Death	<u>'</u>	Inpatient 2	ER/Outpatient			at Work		Home 5 28d. Describe	Residence		er: Scene
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Division Isl or Attendi rs after death. at Director: /	ertification:	2 Accident Inves	stigation 28e Pi	lace of Injury - At I	nome, farm, stre	et, factory,	office bu	ilding, etc	c. :	28f. Location (Street and N	lumber or R	ural Route Number, City
Divis pital or At ours after d ceral Direct filled in by	\frac{1}{2}		d not be Special			,		3.		or Town, S			·
Hospi 24 hou Funer tely fil	ပြ	29a. Certifier 1 Certifying Pt		best of my knowled									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	one) 2 Medical Exam		is of examination									
F > F 8	ž	29b. Signature and title of certifie		11		290	. License	number			29d. Date	signed (M	onth, Day, Year)
			I M.	11			O.C.N	∕I.E.			August	19, 2007	7
	ļ	30. Name and address of person							45.5				· · · · · · · · · · · · · · · · · · ·
				dical Examine		nn Stree	et, Balti	more, f	MD 212	201			
Sta Registr		31. Date filed (Month, Day, Year)		Registrar's Signa	ture	30 0							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 7:44am August Sellers 200 Lillian Gore /Medical 4c. County of Death Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner xorche. ambrida reneral If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
May 2, 192 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** Min 1 ☐ M 2 🔭 F 216-14-2110 Director 86 1921 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at MD Dorchester Yes 2 No Cambridge Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 403 Leonard Lane 21613 USA Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 217 Married 1 ☐ Yes 2X No Specify. white Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 11 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be George W. Sellers Sadie Turner ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Important: If item 27 is any Injury or attention 403 Leonard Lane, Cambridge, W. Hamilton Gore husband MD 21613 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Mem. Park 8/14/07 Cambridge, MD 22. Name and Address of Facility 21. Signatur of Funeral Service Licensee Thomas Funeral Home P.A. U 700 Locust St., Cambridge, MD 21613 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for i in the past 12 months? 1 ☐ Yes 2 de No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknows Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 2**0**0 Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an certificate has page 2 autopsy performed 1□ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 2 R/Outpatient 3 DOA Certification: To 1 Inpatient this 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Natural 5 Pending investigation Injury 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

Hospital or Attending Physician: 24 hours after deatl Funeral Director: filled in by the ပ

> State Registrar

(Check only one)

29b. Signatore and title of certifier

ugene

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

		-	For State Registrar	State of Ma	ryland /		irtment of H tificate of I		na Men	tai Hygi Re	ene,	007	27572
; 989	Physicia	an	1. Decedent's Name (First, Middle, Last)						ate of Death		Year	3. Time of Death
	/Medic	al	DONALD 4a. Facility Name (If not institution, give	EDWIN		G	4b. City, Town, or	Location of [Death (ug.	4c, Coi	2007 unty of Death	
	Examin	er	Peninsula Regional	A/3 A	Cente	R	Salisb		D G G G G		1 / /	comes	
e e	Funeral		5. Social Security Number 6. Se		(In yrs. last		If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. D	ate of Birth Month, Day,	Year)	Cot	place (State or Foreign intry)
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	yland now at		10a. State 10b. County		10c. City, To	own or Loc	cation						10d. Inside City Limits
	e Mar 3a-f st	Director	DELAWARE SUSSEX		SE	EAFOR							1 □Yes 2X No
	with the		10e. Street and Number	T 11T (** 11T 1 X X)			10f. Zip Code 199	72		10		i of What Cou USA	intry?
	ms 23	Funeral	14128 COUNTY SEA	12. Was Decedent E Armed Forces?	ver in U.S.	13. V	Vas Decedent of H f Yes, specify Cubs		n? (Specify	Yes or No-	14.	Race - Amer	
9	be filed within 72 hours after death with the Maryland that Hyglene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1 Never Married 2 Married	1 X Yes 2 □ N	0		r Yes, specily Cuba I∐ Yes 2. X No		Pueno nica	n, etc.)		Black, White	
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21.	filed with Hygiene other tha ent, the	Com	11				TECHNIC		/pm:	-4.84:48-84		DENTAL	
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ar Ži	should be ind Menta marked umatic ev	으	19a. Informant's Name/Relationship (7				g Address (Street			ute Number,			ip Code)
	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		SHARON R. GOODWI	N/WIFE			COUNTY						
Baltimore,	m O >		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	1		sition (Name of natory or other plac		Date			ion - City or	•
<u>=</u>			4 □ Donation 5 □ Other (Specify 21. Signa re of Funeral Service License	-	DELAW		VETERAN (8/16/0)7 M	ILLSE	30RO, 1	DELAWARE
Ba	permit. Departr Importa any inj		> / / Links W	4.			STINGS F		HOME	, SELB	SYVIL	LE, DE	. 19975
			23a. Part Enter the disease, or comp shock, or heart failure. List only	lications that caused one cause of each lin	the death. I								Approximate Interval Between
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Box	The law requires that the death certificate be executed the has been signed by the attending physician and use 2 should be detached for use as the burial-transit.	Physician/M	23b. was decedent pregnant	23c. If yes, outcome 1□Live birth			∃Ectopic pregnanc	4			230	d. Date of deli	very Day Year
P.O. E	ne dea the att hed fo	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of deat	h 5□	Other (specify)					WOTH	Day Teal
<u>ď</u>	w requires that the d been signed by the should be detached		Part II. Other significant conditions or	ontributing to death be	ut not resultir	ng in the u	nderlying cause giv	en in Part I.		23e. Did tob	acco use	contribute to	the cause of death?
rds	quires en sigr uld be	ed by							_	1 ☐ Ye	es 2 🗆 f	No 3□Pr	obably 4 Unknown
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a B										perform	2 DANO	death? 1 ☐ Yes	2 No
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<u>N</u>	lor At after d Direc I in by	Certification:	4 Homicide determined	building, et	c. (Specify)	, iarm, sir	eet, factory, office			City or Town		vumber or mu	ıral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification of the funeral director, completely filled in by the funeral director.			ysician: To the best on the basis of the bas									
	To the High 24 To the Figure 24 Complete	Medical	one)	and manner sta			29c. Licens					signed (Mont	
	2 7 8	-	29b. Signature and title of certifie	7~			1 -5	c=1				- 13	
10)IIIT		30. Name and address of herson who	completed cause of d	eath (Item 23	Ba) (Type,	Print)			9.5	CON I		
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a	aco hl	th	dept 8/13/07 dl State of Maryland / Department of Health and	Mental Hygi	ene,	27573
			1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)	Re 2. Date of Death	g. No.C U /	2. Time of Death
В	Physici	an	Janet Washington Lee Gildea	Month	Day Year 8 2007	3. Time of Death 12:24 AM
No.	/Medic		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	August	4c. County of Deat	
	Examir	er	731 Robin Hood Hill Sherwood For			Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	Year) 9. Birti	nplace (State or Foreign untry) nington D.C.
0	Director		212-34-6180	Oct. 20	, 1935 Wasi	nington D.C.
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	f sho	ō	Maryland Anne Arundel Annapolis Sherwood F	orest		1 □ Yes 2 □ No
	r 28a	irec	10e. Street and Number 10f. Zip Code		g. Citizen of What Co	
	th with	al D	731 Robin Hood Hill 21405		United Sta	ates
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	pecify Yes or No-	14. Race - Ame Black, White	
36	or it	Z.	1 □ Never Married 2 □ Married 1 □ Yes XX No 1 □ Yes XX No Specify:	, ,		hite
21215-0036	hour tural'	q pa	3 ☐ Widowed Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	11	6b. Kind of Business/	ndustry
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bu	al Hyg I othe	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name	ne (First, Middle, M	laiden Surname)	
ylaı	Ment Ment arked aric e	To	Girard Thomas Lee Dorothy	Thomas		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylar to Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Relationship)			
	1 and Health sm 27 ther ti		William P. Gildea IV / Son 533 Little John Hill 20a. Method of Disposition 20b. Place of Disposition (Name of		Forest, M	
Baltimore,	permit. Pages 1 and 2. Department of Health a Important: If item 27 is any Injury or other trau		MYBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)			
Ħ	artme artme ortani Injury		4 □Donation 5 □ Other (Specify) Lakemont Mem. Gardens 8/13 21. Signature of Funeral Service Licensee 22. Name and Address of Facility			
Ba	permit. Departr Imports any Inji		MillO 9 147 Duke of Glouce			s, MD 21401
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	c or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Attended to the condition resulting in death)	aline		Onset and Death
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89	ifficate g phy as the					
Box	h cerr endin	N N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of del	ivery
	e deat	sicia	In the past 12 morths? 1 □ Yes 2 □ No 4 □ Pregnant at time of death 5 □ Other (specify)		Month	Day Year
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	ires the signed	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to s 2 No 3 Pr	obably 4 Unknown
Records,	requ	Completed	Infanta lasmy glasse			
Rec	has by	du		24a. Was an autopsy perform	prior to	topsy findings available completion of cause of
ja	n: The ficate ficate or, pag		25. Was case referred to medical 26. Place of De.	1□ Yes 2	☑No 1 ☐ Yes	2 □ No
or Vital	Physician: this certificanal director,	o Be	examiner?	ath (Check only one	nce 6 □Other <i>(Spe</i>	nifu)
0	g Phy ier thi	n: To	27. Mann Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe ho		sily)
Division	Attending r death. ector: After by the funer	Certification:	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
Ξ	or Att ter de lirect	ij	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str City or Town,	reet and Number or Ru , State)	ıral Route Number,
Ω	urs at eral D	Š	ATTO MILE TO THE PARTY OF THE P		()	
	24 ho Fun etely 1	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only one)			
	To the Hospital or Attending Physician: The law within E4 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Mec	29b. Signature and title of Certifier	29	d. Date signed (Mont	h, Day, Year)
	- Cal		> 11/100/14 /NU 1 05213	9	08/19	7/07
	OCHE		30. Name and address of person who completed cause of death (Item 23a) (Type, Frint)	,	0010	alle MO
	W		SETTL MATO AOI BIONLEMIN BILD S	sures	o bambi	
	Sta Registi	-	31. Date filed (Month, Day, Year) 3 2007 32. Figistrar's Signature			2/02

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State	Ce	rtificate o	f Death		Reg	. No.	11 2/5/
Physician	/ 1	Decedent's Name (First, Middle,Last)				1 N	ate of Death Month	Day Year	3. Time of Death
Medical Examine		William Victor	Greto				ugust 17,	2007 4c. County of Dea	2215 hrs
	4	 a. Facility Name (if not institution, give 1119 Vanguard Way 	street and number)		4b. City, Town, or Loca Bel Air	ation of Death		Harford	iui
Funeral	5	. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)		Under 24Hrs. 8.	Date of Birth	(MM/DD/YYYY) 9. E	Birthplace (State or
Director	- 1		4 2 F 62	Yr	Months Days 1	Hours Min.		Fore	eign
	\perp	Isual Residence of Decedent	7 2 7	113	· .	- 1	JCt. I	8, 1944 °	PA
an No.	· ·	0a. State 10b. County	10c. City	, Town or Loca	tion				10d. Inside City Limits
Aaryland 28a-f show 1 at once.	- 1	Maryland Harford	Bei	l Air		;			1 Yes 2 X No
the Maryland a or 28a-f sh Lifted at one		0e. Street and Number	1		10f. Zip Code		100	g. Citizen of What Co	ountry?
th the Maryland 23a or 28a-f sho notified at once.		1119 Vanguard Way	•		21015		1	USA	
after death with the Maryland all, or items 23a or 28a-f shi iner must be notified at once we Furneral Director	1	1. Marital Status	12. Was Decedent Ever in U Armed Forces?		as Decedent of Hispani /es, specify Cuban, Me			· 14. Race - Am White, etc.	erican Indian, Black,
r deat		1 Never Married 2 Married	1 X Yes 2 No						
rral",	<u> </u>	Widowed 4 XDivorced 1 15. Decedent's Education (Specify only	or Dates:		Yes 2 X No sp		dono I	Specify: 1 16b. Kind of Busines	Vhite .
"natu Exar	na	Elementary/Secondary (0-12)	College (1-4 or 5+)		nost of working life. DO			10b. Killa of Busilles	s/industry
36 bin 72 e. than	ᇍ	Elementary/occordary (o 12)	2	Car	Salesman			Automot:	ive
5-0036 led within 72 hour sygiene. other than "natu	5 1	7. Father's Name (First, Middle, Last)				lother's Name (Fir	st, Middle, Ma		
21215-0036 uld'be filed within 7 Mental Eygene. marked other than e event, the Medica	n n	Frank Albert Gret	.0		Ic	ouise Mar	cy DiM	atteo	
D 21215-0036 should be filed within 72 hours and Mental Bygiene. 7 is marked other than "naturentic event, the Medical Examire To: Re Commissed of	2 1	9a. Informant's Name/Relationship (Typ	•		g Address (Street and				
		Christine Giglio			Dellwood I				
more, N Pages I and ent of Health int: If item	- 1 -	0a. Method of Disposition 1 Burial 2 XCremation 3		crematory or o	sition (Name of cemete ther place)	ry, Da	ite	20c. Location - City	or rown, State
Page Page ment tant:	4	Donation 5 Other Specify:	, H	illtop :	Service Con	np 8-24	-07	Towson, 1	Maryland
Baltimore, permit. Pages I ar Department of Hee Important: If ite	2	1 3 go ture of Funeral Service License	ee /	² M	Name and Address of F CCOMAS Fune	eral Home	P.A	•	
	(3a. Part I. Enter the disease, or compli	July de la d	1 1	317 Cokesbi	irv Road	. Abin	adon, Mars	rland 21009 Approximate Interval
Physician /Medical	'	failure. List only one cause or date	n line			. as caldiac of les	piratory arres	st, snock, or near	Between Onset and Death
Examiner			1coho1 and cocat ue to (or as a consequence		ication_	,			. Death
		Sequentially list conditions, b	ac to (or as a consequence	01).					
ğ	i ii	f any, leading to immediate D	ue to (or as a consequence	of):, ,					B B B
ted Insit		Disease or injury that initiated C.	ue to (or as a consequence	of):					+
ecuted and - transit	֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟	d							
is as as	200	X UNPENDED	AMENDED #23a,27,28a-f,	nerMF a8	70 8/30/07 T	T			
760, frate be executed physician and the burial - transi		F FEMALE:	23c. If yes, outcome of pre	gnancy	_			23d. Date of deliv	ery
		Bb. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at time of o	eath		Ectopic pregnancy		Month	Day Year
D. Box 68' t the death certification by the attending ached for use as!		Yes 2 No 9 Unknown	9 Unknown	eath 5 C	ther (Specify)				
that the de ned by the detached f	Ē	Part II. Other significant conditions	contributing to death but not	resulting in the	underlying cause given	in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
P.C. res that signed be deter	5						1 Yes	2 🗸 No 3 P	robably 4 Unknown
Records, The law requires fricate has been sig.						2	24a. Was a		autopsy findings available o completion of cause of
e law e has ge 2 sl	Ē		· ··				perform	ned? death	
Vital Rec ysician: The his certificate l director, page		5. Was case referred to medical			26.Place of D	Death (Check only		V NO	res z No
Vita hysician this cer direct	ומ		spital: 1 Inpatient 2	ER/Outpatier	I Oth		, , , , ,	Residence 6 🗸 Ott	ner: Scene
Division of Vital Records, P.O. tal or stending Physician: The law requires that the rs after death al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach briffication: To Re Commisted by P.	- 2	7. Manner of Death	28a. Date of Injury (Month, Day, Yeer)	28b. Time of	Injury 28c. Injury at	Work? 280	. Describe h	ow injury occurred	
ion tendir eath tor: A		1 Natural 5 Pending 2 Accident Investigation	End 8/17/2007	Fnd 10	:10 pm 1 Yes	2 X No	ınk		
Visi or Att fler d Jirect in by	<u> </u>	2 Accident Investigation 3 Suicide 6 X Could not be	00 01 11 11		eet, factory, office buildi	ing, etc. 28f	. Location (St		Rural Route Number, City
Division o spital or Attending tours after death neral Director: Aft filled in by the fune	1 P	4 Homicide determined		residenc	e	111	19 Vangu	ard Way Bel	air, MD
		Check only	n: To the best of my knowle	-					
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ا و		On the basis of examination and manner stated.	anu/or investiga			a unie, date a		
2	2	9b, Signature and title of certifier	Mr		29c. License nu O.C.M.E			29d. Date signed (# August 18, 200	
		NUVIO	110		U.C.IVI.E	•		August 10, 200	
	3	 Name and address of person who co Susan Hogan MD. Assis 	impleted cause of death (Ite cart Medical Examine		nn Street, Baltimo	ore. MD 2120	1		
Stat	2 3	1. Date filed (Month, Day, Year)	32. Registrar's Signa)				
Registra		AUG 2 8 20	a. em 97.	A Son	BARL D				

			For State Registrar	State of Maryla		artment of F			ene g. No. 200	7 2757
b:	Physici /Medic	al	Decedent's Name (First, Middle, Last) RAYMOND PER 4a. Facility Name (If not institution, give si		ID .	4b. City. Town. o	r Location of Death	2. Date of Death AUG • 7	7 Day 200 Year 4c. County of Dea	3. Time of Death 7:15 A M
	Examin Funeral	2	Casey House 5. Social Security Number 6. Sex	7. Age (In yr	s. last birthday)	Rock V	Jille	8. Date of Birth	MONT	GOMERY thplace (State or Foreign ountry)
ď.	Director		215-46-1555 Usual Residence of Decedent 10a. State 10b. County	M 2 F 62	Yrs. City, Town or Lo		I	(Month, Day, 1	_945 M	aryland 10d. Inside City Limits
	h the Maryl or 28a-f sho s notified a	irector	MD Montgom	nery	Ge:	rmantown	n	10	g. Citizen of What C	y Yes 2 No ountry?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	19633 Rhinest 11. Marital Status	2. Was Decedent Ever in Armed Forces? 1 Yes, Give Year or Dates:	U.S. 13.		20874 Ilspanic Origin? (Specan, Mexican, Puerto R Specify:	cify Yes or No- lican, etc.)	U.S. 14. Race - Am Black, Whi Specify: B	erican Indian, te, etc.
Maryland 21215-0036	vithin 72 hou sne. Ihan "natura Ie Medical E:	Completed I	15. Decedent's Educ (Specify only highest grade	ation	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of working	g 1	6b. Kind of Business	
land 2	should be filed withind Mental Hygiene. Transked other than umatic event, the Mental Hygiene.	To Be Co	12th 17. Father's Name (First, Middle, Last) James M. Holl	.and	11,	oubenee.	18. Mother's Name	(First, Middle, Middle	aiden Surname)	
	it and 2 shou Health and M tem 27 Is mai		19a. Informant's Name/Relationship (Type Alise Burriss (20a. Method of Posposition	(Sister)	820	5 Warfi	eld Rd.,	Gaithe		MD 20882
Baltimore,	1 Burial 2 Cremation 3 Removal from State 4 Copyright 5 Other (Specify) 21. Signifure of Funeral Service Licerspe 22. Name and Address							OWDEN B	UNERAL	burg, M D HOME, P.A. ,MD 20850
)	Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heard allure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the de e cause on each line. Renal Due to (or as a conse	ath. Do not en	ter the mode of dyir				Approximate Interval Between Onset and Death
3760,	be executed sician and burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse						
.O. Box 687	death certificate e attending phy. d for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf preg 1 ∐ Live birth 2 ∐ Fe 4 ∐ Pregnant at time o 9 ∐ Unknown	etal death 3	□Ectopic pregnanc	у		23d. Date of do	blivery Day Year
Δ.	juires that the de n signed by the a lid be detached i	þ	Part II. Other significant conditions con Prostate Ca		esulting in the u	nderlying cause giv	ren in Part I.	23e. Did toba		to the cause of death? Probably 4 □Unknown
Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed	Colon Cance	er				24a. Was an autopsy perform	prior to	autopsy findings available completion of cause of
or Vital	yslcian: is certifica director, p	To Be C	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 ☐ Inpatient 2	☐ ER/Outpatie		4 ☐ Nursing Horr	(Check only one)	ecify)Hospice
Division o	or Attending fter death. Director: After in by the funer	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At building, etc. (Spe	home, farm, st	M 1□	Yes 2 □ No		w injury occurred eet and Number or I State)	Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	(Check only 2 Medical Examination)	sician: To the best of my k ner: On the basis of exami and manner stated.		nvestigation, in my	opinion, death occurre	ed at the time, da	ate and place, and d	ue to the cause(s)
	To t withi To t	Σ	29b. Signature and title of certifier	delessi	W)		0646()		8-7-07	nth, Day, Year)
1	3		30. Name and address of person who co				aster Mil	1 Rd.F	Rockvill	e.MD 20850

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

AUG 1 5 2007 | Seem & Species

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician Albert Harris SRI August Leon 10 2007 0300 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospita 6. sex, Easter Memorial 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 100 M 2□ F Months Hours Min Davs 218-16-6890 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director Talbot Cordova 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? Kipton-USA Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 PYes 2 If Yes, Give Year or Dates: 2 No 1946 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Black Completed by 3 Widowed 4 Divorced 1947 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Be SSie T.19hMan ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 98135Kipton-Cordova Rd. Cordova, MD. 21625 Nora 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ns Cometery 8/15/07 Hurlock, MD 22. Name and Address of Facility HENRY Fune Ral Home, P.A. 510 Washington St. Cambridge, MD. 2/6/13 4 ☐ Donation 5 ☐ Other (Specify) Veterans 21. Signature of Funeral Service Licensee C. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cancer Mortus /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi Due to (or as a consequence of): physician at the burial P.O. Box 68760 Physiclan/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9☐Unknown 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1☐ Yes 2 No **Division or Vital** funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

State Registrar 29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regierar's Signature

Year) 5

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month William Paul Hartshorn 2007 1150 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HICOMICO MINSHLA 544156414 Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 81 Days Hours 1**X** M 2□ F 222-10-8369 Director 5/22/1926 Delaware Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10c. City. Town or Location 10b Counts r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Wicomico Salisbury 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 200 Troopers Way 21804 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 127 Yes 2 □ No If Yes, Give Year or Dates: Navy 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🛣 No 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 career military U.S. Navv or other traumatic event. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental James Hartshorn Ann Bradley and l 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: if Item 27 is
any Injury or other trau 200 Troopers Way, Salisbury, MD 21804 Rosemarie Hartshorn/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 8/14/07 Salisbury Crematory Salisbury, MD 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21904 Funeral Service Licenses Javie A. Charaman CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical to (or as a consequence of 3 **Examiner** Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the bunal-tran and signed by the attending physician Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an Was a... autopsy performed Yes 2 has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No r 1 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29b. Signature and title of certifier

ONAR

State Registrar 30. Name and address of p amin

AUG

(Item 23a) (Type, Print)

32.

2007

egistrar's Signature

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 2007 Eva Myrtle Herrell 21:37 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M **XX** F 165-22-3118 Dec. 8, 1927 79 Pennsylvania Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland I and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits must be notified at 1 ☐ Yes 2XXVIo Directo Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be n once. 618 Lake View Drive 21403 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify è Specify: White 3 ₩Vidowed 4 Divorced Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Thomas Clyde Busch Dollie Orphie Allshouse 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George J. Herrell / Son 618 Lake View Drive Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Memorial Gardens Annapolis, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licensee Mil 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the burial-transi attending physician and Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA al or Attending Pl s after death. al Director: After ti 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital o the Funeral within 24 hours 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier edical and manner stated. 29c. License number 29b. Signature and title 29d. Date signed (Month, Day, Year) D0005 5297 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sel Medical Carte MO Anne HOWARD

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day,

AUG 1 3 2007

Division or Vital Records, P.O. Box 68760,

egistrar's Signature

Physician /Medical Examiner	
Funeral Director	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 45 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit WH-3

		For State Registrar		,	Certi	ficate of L	Death		Re	g. No. 2	1117	27	57
		1. Decedent's Name (First, Middle	e, Last)						2. Date of Deat Month	n Day	Year	3. Time of	Death
sicia edic		MARY ELIZABET	TH HARRIS						AUGUST		2007	4:05	P^{M}
mine		4a. Facility Name (If not institution	, give street and number)	4	b. City, Town, or	Location of	Death		4c. Count	of Death		
	u	WASHINGTON COUR					GERSTO			WA	SHING		
ral or		5. Social Security Number 218–24–9574	6. Sex 7. A	ge (In yrs. last bir 98		f Under 1 Year Ionths Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, DEC 9,	^{Year)} 1908	Coun	place (State or htry) RYLAND	Foreign
	_ H	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Locat	ion					1	0d. Inside Cit	Limite
	. 1			Too. Oily, Town	TOT LOOU.							1 ☐ Yes	
	Director	MARYLAND WAS 10e. Street and Number	SHINGTON			KNOXVII	LLE		14	Da. Citizen of	What Cour		24
) A D				21750		1 "	J		itiy:	
	era	620 WEVERTON RO	JAD 12. Was Deceden	Ever in U.S.	13. Wa		21758 ispanic Orig	in? (Sp	ecify Yes or No-		S.a. ce - Americ	an Indian.	
	Funeral	1 ☐ Never Married 2 ☐ Marr	Armed Forces ied 1 ☐ Yes 2 €	?	1 _			Puerto	ecify Yes or No- Rican, etc.)	Bla	ck, White,	etc.	
	2	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 -	Yes 2∏∑ No	Specify:			Specia		нтте	
	Completed	15. Deceden	t's Education st grade completed)	16a.		t's Usual Occupa d of work done o		of work	ina	16b. Kind of E			
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	Be	17. Father's Name (First, Middle,	,						e (First, Middle, N		,		
٤	욘 .	JOHN WILLIAM TH		105	B.4 - 10 1	\dd /044			LIZABETH			0 11	
		19a. Informant's Name/Relations			_				al Route Number	•		,	70
1	-	SUE ANN UTTERBA 20a. Method of Disposition	ACK/NIECE	20b. Place of	Dispositi	on (Name of	i		HRERSVII	MA et location			79
		1 🖫 Burial 2 ☐ Cremation 4 ☐ Donation ↑ 5 ☐ Other (S		•	-	ory or other plac	1	/1 7	(0007				
6	-	21. Signature of Funeral Service		OPD B		SVILLE_C ame and Addres			7606 01			, MARYI	_AND
once			Kelly A.	Zimmerma	n BAS	ST FUNER	AL HO	ME	Boonsbo				13
		2 art1. Enter the disease, or shock, or he rt fail ve List				he mode of dyin	g, such as o	cardiac			7 - 7 - 7 - 7	Approximate Interval Bety	
an		Immediate Cause (Final disease or condition	44 S	Dalla	THI	0	21400	211			1	Onset and D	
al		resulting in death)	Due to (a	s a consequence	of):		-10		-				
er	.	Sequentially list conditions,	ь Р О	2110		DISS	· EC	11	ON				
	ine	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence	·	20014	1414.		م م الحاد ه	11.2 =1	DIM	ı	
	Examine	that initiated events resulting in death) Last	c. Due to (or a	s a consequence		SPU H	INA (JORTIC	AN BU	reysi		
					,-								
	Medical		d										
	_	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			And the same of				23d. D	ate of deliv	ery	
	icia	in the past 12 months?	4□Pregnant	2 ☐ Fetal death at time of death		ctopic pregnancy ther <i>(specify)</i>	′				onth		'ear
	hys	1 Yes 2 No 9 Unknown	9□Unknown										
	Completed by Physician	Part II. Other significant condition	ons contributing to death	but not resulting in	n the unde	rlying cause give	en in Part I.	1)(1	23e. Did tob	acco use cor		he cause of d	
1	ted	ACULBREN	arc by	LUKE	,	HYPE	12 (0	NZ	1 0 V 1 □ Y 6	es 2 No	3 ☐ Prol	pably 4 X L	Inknown
	ple	CONGESTIV	6 HOA	76 6	41	-ULB,			24a. Was a	n 24b	Were auto	opsy findings a mpletion of ca	available luse of
	S S	HUPOTHURE	ID RTA	78					perform 1⊟ Yes	ned? No	death? 1 □ Yes	2□No	
	Be	25. Was case referred to medica examiner?	Hospital: • •			Oth		of Deat	h (Check only on	e)			
	2	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of In		tpatient Time of	3 DOA Oth	4 🗆 1901		ome 5 Reside			fy)	
	ion	1 Natural 5 ☐ Pendir	g (Month, D		njury	28c. Injur Worl	yau k? Yes 2 □ N		200. Describe no	w injury occu	rreu		
	fica	3 Suicide 6 Could	not be 28e. Place of in	jury - At home, fa	ırm, street			-	28f. Location (St	reet and Num	ber or Run	al Route Num	ber.
	erti	4 ☐ Homicide determ	building, e	etc. (Specify)					City or Town	n, State)			
	Medical Certification:	29a. Certifier 1 ertifyii (Check only 2 Medical	ng Physician: To the bes Examiner: On the basis	t of my knowledge of examination ar	e, death o	ccurred at the tir	ne, date and	d place,	and due to the c	ause(s) and n	nanner as s	stated.)
-	Medi	one)	and manner s	tated.									,
	_	29b. Signature and title of certifie		. ^		29c. Licens	e number	- A	,	9d. Date sign	ea (Month,	Day, Year)	
	4	- une	usterl)	(U).	/T	DOO	633	54	600	6 10 -	AN-	7	C705
		30. Name and address of person HBRLY. KURH	ATY , WACH	INGTON	Type, Pri	00074	HOSPI	TAL	MAC *	DO TO	ا داده	10-5	21211
Sta	e	31. Date filed (Month, Day, Year)		trar's Signature					गुरुष्	100	11 10	-113 6	x 146
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. 1/00	04												

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Preston Joiner 0857 AM 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Easton Talbot memorial Hospital at Easton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 02703724 ear) **Funeral** Hours Days 1**X** M 2□ F 83 Director 217-30-7714 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 Yes 2 No Rock Hall Director MD Kent 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21661 5795 Chesapeake Villa Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Seafood Joiner, Prestor <u>Waterman</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jennie Lee Thomas Weldon Joiner ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20964 Rock Hall Ave. Rock Hall, MD 21661 Nila Hinefelt/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 \ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Wesley Chapel Cem. 08/12/07 Rock Hall, MD 5 ☐ Other (Specify) 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Service Lice 21. Signature 130 Speer Rd. Chestertown, MD 21620 Approximate Interval Between Ogset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of deart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, the sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate memon 1□ Yes ~2√ No director, 25. Was ase referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 8 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) Natural 2 Accident 5 Pending investigation 1 □ Yes 2 □ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Hospital or Attending Physician: nours after death.

Ineral Director: After this of y filled in by the funeral dire within 24 hours at To the Funeral C completely To the

State

Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 19ay 2007 **Physician** 6:30A M BERNARD MICHAEL KELLY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner WASHINGTON AUTUMN ASSISTED MEMORY HAGERSTOWN, CARE MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 3 1 3 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1)X) M 2□ F 214-07-2396 1918 89 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ral', or iteme 23a or 28a-f show Examiner must be codified at YYes 2 □ No MD WASHINGTON HAGERSTOWN Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES 310 CAMEO DRIVE 21740 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify Specify: 1945 þ 3 ♥ Widowed 4 Divorced WHITE "natural" or than "natural Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be fitled within Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "I eny injury or other treumetic event, tra Mesons. Elementary/Secondary (0-12) College (1-4 or 5+) REALTOR REAL ESTATE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) JOHN LEE KELLY HELEN M. ZELLER KELLY 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CYNTHIA MOLER 18935 Manchester Drive Hagerstown, MD21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State * 4 Donation 5 Other (Specify) FROSTBURG MEMORIALPARK8-25-2007 FROSTBURG, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 60 W. Main St. SOWERS FUNERAL HOME, P. A. Frostburg, MD21532 760 m00547 200 Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Acu m /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physicion: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year õ in the past 12 months?
1 Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 🗌 Yes 2 🗌 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an D certificate has autopsy performed 1 Yes 2 3 No Be 25. Was case referred to medical 26. Place of Death (Check only one) ASSISTED examiner Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Ofther (Specify) W/10 2 1 Yes 2 No 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Injury 1 Matural 1 Yes 2 No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2.30 DT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Mb 21740 AL VASAIST 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 8 2007 Registrar

DHMH 17 Rev 1/2001

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			Registrar 1. Decedent's Name (First, Middle, Las	t)	_	007	tinca	ic or L	Calli	:	2. Date of Dea	Reg. No.		-	3. Time of	Death
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Baltimore,	Pages 1 nent of H ant: If Ite ury or ot		20a. Method of Disposition 1 ☐ Burial 2 🏹 Cremation 3 ☐		e	Place of Dispo cemetery, crea			1 '	Augus	it		cation - City			
量	permit. Page Department of Important: If any Injury or once.		4 □ Donation 5 □ Other (Specify 21. Signature 1 = 1 Un		May	yerdale	2. Cre	mator and Addres	cy s of Facilit	13, 2	2007 ouch Fu	Newa	rk, D	ela	ware	
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9		Med	IF FEMALE:	000 16											<u> </u>	
Вох	attenc for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant	2 ☐ Feta	aldéath 3[⊒Ectopic ⊒ Other (pregnancy				2	3d. Date o' Month		-	Year
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	stcian: The law requires that the death certific certificate has been signed by the attending r rector, page 2 should be detached for use as		Part II. Other significant conditions of	ontributing to death	but not res	ulting in the u	inderlying	cause give	en in Part I		23e. Did t	obacco u	se contribu	te to th	ne cause of c	leath?
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	8		30. Name and address of person who	completed cause of	f death (Iter	m 23a) (Type,	, Print)	0	1 3	~		Juga	01/4	1		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 08/12/2007 **Physician** 0015 Catherine Sadee Klamp /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Kent Chestertown Chester River Hospital Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 🔀 F MD 85 09/06/1921 214-18-1570 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show be notified at 1 ☐ Yes 2 X No Director MD Stevensville Queen Anne's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 filed within 72 hours after death with USA 21666 110 Point Rd. 'natural", or Items 23a the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 þ 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Manufacturing Bookkeeper permit. Pages 1 and 2 should be filed obpartment of Health and Mental Hygid Important: If Item 27 Is marked other any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Swiderski Peter Grabowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 110 Point Rd. Stevensville, MD 21666 Henry Klamp/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2 Kremation 3 ☐ Removal from State 8/14/07 Stevensville,MD Chesapeake Cremation 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 106 Shamrock Rd. Chester, MD 21619 21. Signature of Funeral Service Lix nsee Fellows, Helfenbein & Newnam Funeral Home, P.A. Brick Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician once disease or condition resulting in death) /Medical Due to (or as a c) nsequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as the IF FEMALE use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 🕱 No 4☐ Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 1 No 24a Was an 1□ Yes funeral director, 25. Was case referred medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To this 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Mann 28a. Date of Injury of Death After (Month, Day Year) Injury 5 ☐ Pending investigation 1 Latural 1 □ Yes 2 □ No n 24 hours after death.

The Funeral Director: A pletely filled in by the 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

State Registrar 30. Name and address of person who complete

31. Date filed (Month, Day, Year)

TEXA

AUG 14

DHMH 17 Rev 1/2001

ORIGINAL

d cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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			For State					Certifica	ate of	Death) 				Reg. No.			
	Physicia		. Decedent's Name	(First, Middl	e,Last)								2	Date of De	eath Dav	Year	3	3. Time of Death
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MD 21215-0036	permit. Pages I and 2 should, be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene. Integrate: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical I raminer must be notified at once injury or other traumatic event, the Medical I saminer must be notified at once	-1	Helen Mc												MD 21			
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sio	or Attend after death. Director: I in by the	cati	2 Accident	inv	estigation	28e P	lace of Ini	ury - At home,	farm, stre	et, factor	v. office b	uilding, e	tc.	28f. Locati	on (Street a	and Numb	er or Ru	ural Route Number, City
<u>.</u> ≥	Hospital or A 24 hours after Funeral Dire	rtifi	3 Suicide		uld not be termined	(Speci		ury richomo,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,,	3,			vn, State)			
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State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death **Physician** 1920 PM Frances 0. Loudermilk August 11, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elkton Cecil Union Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 X F 63 432-76-8379 02/29/1944 Director Arkansas Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show a or 28a-f show t be notified at Cecil Elkton 1 X Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 6F Glen Creek Circle USA Items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government and Mental Hygiene Is marked other than Mail Carrier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Etheridge George McKinzie 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 Is any Injury or other trau 6F Glen Creek Circle, Elkton, MD 21921 Tiffary Lum / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harford Memorial 20a. Method of Disposition Date 20c. Location - City or Town, State 1 TBurial 2 ☐ Cremation 3 ☐ Removal from State 08/16/07 Aberdeen, MD 4 ☐ Donation 5 ☐ Other (Specify) Gardens 21. Signature of Funeral Service License Strano & Feeley Family Funeral Home 635 Churchmans Road, Newark, DE 19702 Edwas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute **Physician** 47 poxec respiratory 2 24 Levri /Medical Due to (or as a consequence of): Examiner Post - obstructue Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physiclan: The law requires that the death certificate be executed nouswell and joyall cell long Mixed Stage TV attending physiclan and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, CHACK Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed, 2 X No certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0055190 AUGUST 11, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) fred Union Hospital 106 Bow Street Elkton MD 21921 PIPPO MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month 0630 AM 4 461151 2007 Elaine F. McNally 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. I & Down HARFORE NURSING 1112ENS 8. Date of Birth (Month, Day, Yea March 29, 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, **Funeral** Min. Days Hours 1 M 2 M F 1932 Pennsylavania 75 Director 555-40-4430 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show "natural", or items 23a or 28a-f sh edical Examiner must be notifled 1 Yes XXNo Director Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21085 USA 2 should be filed within 72 hours after death w n and Mental Hygiene. is marked other than "natural", or items 23s 504 Wycliff Ct Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2€ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. Specify: White þ 3 Widowed 4 ☐ Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Government civil service 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Mitzi Snyder Lewis A. Singer 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trains 9016 Lakes Blvd., West Palm Beach, FL 33412 Rebecca J. Glassner (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 8/28/2007 4 Donation 5 Dother (Specify) Arlington National Arlington, VA 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death neumon Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner equeritally list our dillers, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transi and Due to (or as a consequence of) P.O. Box 68760 attending physician be Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) signed by the a Id be detached for 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Onknown Completed should been : 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perform certificate 1□ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 Yo completely filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ျ After this 27. Manner of Death Natural 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 0

State Registrar

within 24 hours a

To the Funeral I Hospital

29a. Certifier

(Check only one)

30. Name and add

29b. Signature and title of certifier

Medical

who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 1710 M 2007 4a. Facility Name (If not institution, give street and number) /Medical 4c. County of Death Examiner Salisburg Medical enter eninsula Re Wicomico alonal Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days 1 □ M 2 🗙 F Min. 7190 Director 145- 22-Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No COMICO Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USH Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Black, White, etc. 1 ☐ Never Married 2 Mamied Maryland 21215-0036 1 ☐ Yes 2 No Specify BLACK 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TERDUE LABORER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UGHES LES 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) OSEPHINE , SAUSBURY Date MD 21802 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) 1. Signature of Foneral Service Licensee 22. Name and Address of Facility SMITH F/H SALISBURY MD 2180 ST LSABELLA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SP **Physician** hock (/Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit certificate be executed MARY Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. i signed by the Eld be detached t 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 TYes 2 **X**No 3 ☐ Probably 4 ☐ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has by page 2 s autopsy After this certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital rifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stree

Elm

AUG 1 4 2007

31. Date filed (Month, Day, Year)

4110055

32. Registrar's Signature

D 63499

WILSON PIND, MD

08/13/07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- $\frac{For}{State}$ Registrar $\frac{08}{17}$ /07, T.M., Kent Co. Amended # 2 Certificate of Death ecedent's Name (First, Middle, Last) 2. Date of Death $_{\text{Day}}13$ Month Year **Physician** 1850PM CAROCI /Medical Facility Name (If not institution, give street and number) City, 4c. County of Death **Examiner** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 1 M 2 □ F **Funeral** Months Days Hours 214-30-8322 74 0/14/32 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 X No Director MD Queen Anne's Millington 10f. Zip Code 10g. Citizen of What Country? 308 Chester River Heights Rd. 21651 "natural", or Items 23a USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify White 9 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Construction 12 should be filed w h and Mental Hygies is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Adaryn,

Jes 1 and 2 should be sent of Health and Me
Artant: If item 27 is rr

ny injury or other tr Clarence Perry Marvel Mary Weller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Marvel/Wife 308 Chester River Heights Rd. Millington, MD 21651 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If itel any injury or oth 1 Burial 2 Cremation 3 Removal from State 8/18/07 Stevensville,MD 4 Donation 5 Other (Specify) Chesapeake Cremation 9/10/0/ Stevensville, Fill 22. Name and Address of Facility Fellows, Helfenbein & Newnam 21. Signature of Funeral Service Licensee 130 Speer Rd. Chestertown, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Physician NUTASTATIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ NO 24a. Was an ate has bage 2 s autopsy performed? director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 1. Natural 28a Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: if or Attending Patter death. After (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 ☐ Homicide within 24 hours a To the Funeral I the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signafu

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State 31. I Registrar

30. Name and address of person w

1. Date filed (Month, Day, Year)

AUG 1 4 2007

ho completed cause of death (Item 23a) (Type, Print)



STES CHESTER TOWN, NO 2160

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SIFE

		,	1 - For Amend Item	State of Ma 24a per	arylan verb	d / Depa	artment o	of Health	and Me	ntal Hyo	giene Reg. No. 2	107	2758
	機	50)	1. Decedent's Name (First, Middle, Last))					2.	Date of Dea		.,	3. Time of Death
	Physicia /Medic		Kobert			N	led			Month OS	Day	aco 7	8:20A
	Examin	-	4a. Facility Name (If not institution, give	street and number)			1	wn, or Location	of Death		4c. Cour	ity of Death	0011
	Examin	85	Constrol Hospice	atthe L	ales		5	alish	irvu		4	Vicor	nice
10	Funeral	1.2	5. Social Security Number 6. Sec	x 7. Age	(In yrs.	last birthday)	If Under 1	ear If Under	r 24 Hrs. 8.	Date of Birt	h	9. Birthp	slace (State or Foreign
	Director		044-26-1258	M 2□F	72	Yrs.	Months E	ays Hours	Min.	(Month, Day	y, Year) 1935	Coun	necticut
	TO TO		Usual Residence of Decedent							dire 17	, 1755	1 00111	recereue
	ylan how at		10a. State 10b. County		10c. Cit	y, Town or Lo	ecation					1	0d. Inside City Limit
	Ma-f s ified	Stol	MD Wicomic	0	W	llards	3						1 □Yes 2XN
	h the	Director	10e. Street and Number				10f. Zip Co	de			10g. Citizen o	f What Cour	ıtry?
	death with the Maryland ms 23a or 28a-f show r must be notified at		35275 Cobbs Hill	Road			2	1874			U.S.	Α.	
	deat ms ;	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	er in U.	.S. 13.	Was Deceden	t of Hispanic Or Cuban, Mexica	rigin? (Specif	y Yes or No-	14. R	ace - Americ	
٥	after or Ite		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2X N	10	1	1 ☐ Yes 2 ☑			an, etc.)		lack, White,	etc.
2-0030	72 hours after natural", or Ite dical Ex. mine	by	3 ☐ Widowed 4 🔼 Divorced	Year or Dates:			TLI Yes 212	No Specify	·:		Spec	oify: wh	nite
ה מ	72 hc natu	tec	15. Decedent's Edu (Specify only highest grad	cation			dent's Usual C		et of working		16b. Kind of	Business/Inc	dustry
7	within iene. than "i	agr.	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	DO NOT use i	lone during mo etired)	or or working				
V	d wi	Completed		4		Resi	pirator	y Thera	apist		Hea1	th Car	e
9	be filed within 72 hours after death with the Marylar ital Hygiene. A other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Be (17. Father's Name (First, Middle, Last)					18. Moth	er's Name <i>(F</i>	irst, Middle,	Maiden Surn	ame)	
<u>a</u>		To	Unknown					Un	known				
a	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Ty	pe. Print)		19b. Maifii	ng Address (S	treet and Numb	er or Rural F	Route Numbe	er, City or Tow	n, State, Zip	Code)
Ξ	27 mg		Crawford Rayne	(Friend)		3527	5 Cobb	s Hill	Rd. W	illar	ds, MD	2187	4
9	es 1 a of Hea		20a. Method of Disposition		20b. F	Place of Dispo	osition (Name matory or othe	of place)	Date	е	20c. Location	n - City or To	own, State
аппо	Ö ← – o		1 ☐ Burial 2 【XICremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)					lmarva	8-14-2	:007	Delma	r, Del	laware
	nit. Pa artmen ortant: injury e.		21. Signature of Funeral Service Licens		prei	2:	2. Name and A	ddress of Facil	lity		DCIMA	r, Del	Laware
Ď	Department on conce		1 The was	A.		S	hort F	uneral	Home		DE 100	140	
	1		23a. Part1. Enter the discusse, or compleshock, or he a fail re. List only of	ic tions that caused	the deat	h. Do not en	ter the mode of	rove St	s cardiac or r	mar,] espiratory ar		740	Approximate
	Physician		shock, or he stalk re. List only of Immediate Cause (Final disease or condition	ne conston each lir			ARCIN		OF		-0~		Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as		uence of):					0 / -		
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-		ner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as	a conseq	uence of):							
	cuted d ansi	Examiner	Cause (Disease or injury that initiated events	0									
<u>,</u>	be executed ician and burial-transit		resulting in death) Last	Due to (or as	a conseq	uence of):							
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200	iclan: The law requires that the death certificate be executed certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			-				23d. [Date of delive	erv
Ď	leath afte	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1∐Live birth 4⊡Pregnant at			∃Ectopic preg ∃Other <i>(spec</i>					Month	Day Year
ġ	the c y the ichec	ıysi	9 Unknown	9□Unknown									
<u>,</u>	that led b deta		Part II. Other significant conditions co	ntributing to death b	ut not res	ulting in the u	nderlying caus	e given in Part	I.	23e. Did to	obacco use co	ontribute to the	he cause of death?
2	uires sign d be	d by								101	Yes 2 No	3 ☐ Prob	oably 4 ☐Unknow
ecords	requestion of the construction of the construc	Completed											
ē	e 2 sh	du								24a. Was autor	psy	prior to co	ppsy findings availab impletion of cause of
=	The page	So									ormed? 2 XNo	death? 1 ☐ Yes	2 🗆 No
VICAL	clan; ertific sctor,	Be (25. Was case referred to medical examiner?						e of Death (0	Check only o	one)		
5	is is	To	1 Yes 2 XNo	Hospital: 1 Tippatie		ER/Outpatier	nt 3 DOA	Other: 4 □ N	lursing Home	5 ☐ Resid	dence 6 □0	Other (Specif	(y)
	ng P	Ë	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Dáte of Inju (Month, Da	ry / Year)	28b. Time of Injury	of 28c	Injury at Work?	280	d. Describe l	how injury occ	urred	
VISION	ath.	atic	2 Accident investigation				М	1 ☐ Yes 2 ☐]No				
5	ar de rectc by th	ific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inju- building, et	ury - At ho	ome, farm, st	reet, factory, c	ffice	28f	Location (S City or Tox		mber or Rura	al Route Number,
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	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral		29a. Certifier 1 Certifying Phy	sician: To the best	of my kno	wledge, deal	h occurred at	the time, date a	and place, an	d due to the	cause(s) and	manner as s	stated.
	ne Hk n 24 ne Fu	Medical	(Check only 2 Medical Examone)	iner: On the basis of and manner sta	r examina ated.	ation and/or ir	ivestigation, ir	my opinion, de	eath occurred	at the time,	date and place	e, and due t	o the cause(s)
	To th Withir To th	Me	29b. Signature and title of certifier)			29c. L	icense number			29d. Date sig	ned (Month,	Day, Year)
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State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 0429 AM en rquist onn arle 2007 /Medical 4b. City, Facility Name (If not institution, give street and number) or Location of Death 4c. County of Death Examiner ent hester 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, Year) 07/09/1935 Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) Funeral 1X M 2□ F Months 72 Washington, D.C. Director 577-46-0677 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ss 1 and 2 should be filed within 72 hours after death with the Marylar of Heath and Mental Hygiene. It has 23a or 28a-f show then 72 is marked other than "natural", or items 23a or 28a-f show cother traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Queen Anne's Centreville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21617 218 Malcolm Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 1955–59 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 □Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineering Program Manager Electronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Catherine J. Bauman Karl R. Newgent 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Newgent/Wife 218 Malcolm Drive, Centreville, Maryland 21617 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of I Department of Important: If it any injury or o 1 ⚠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Memorial Gardens | 08/14/2007 Davidsonville, Maryland f Juneral Service 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. Wha Illu 2973 Solomons Island Road, Edgewater, Maryland 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ATHOROSCURROTTE CARPIONASCULAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dusito (or se a consequence of) Examine nding physician and use as the burial-transi resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CANCER 1 Yes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 R/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

certificate be executed Box 68760. Ö ₫. Division or Vital Records,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral !

Medical

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title of certifier

KENT COI DOPUTY MODICAL OXAMINOR

29c. License number 00057509

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Dav. Year) 8/10/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Lacey, M.D.

MILREAD B-020500 31. Date filed (Month, Day Year,

AUG 1 3 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend 28a, perMF, g871, 9/15/07 TT Certificate of Death Month 08 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** MARY PRACHT 20° 2007 0333 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WMHS - MEMORIAL CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 F 81 Director W 234-42-9390 Sept.3,1925 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notifled at Yes 2 □ No Director W Paw Paw Morgan 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25434 USA 460 Ambrose Ave. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes ② No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2000No Specify: Specify. δ 3€Widowed 4 □ Divorced White Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Telephone Operator Telephone Co. 12 should be filed w h and Mental Hygie 7 is marked other tl 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Lucy C. Heare Frederick W. Lupton ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paw Paw, WV 25434 Kenneth Pracht (son) P.O. Box 357 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 8/22/07 4 Donation 5 ☐ Other (Specify Mt.Zion Cemetery Augusta, W 22. Name and Address of Facility McKee Funeral Home Inc. 21. Signature of Juneral Service Lice P.O. Box 270 Augusta, WV 26704 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final **Physician** disease or condition resulting in death) Intracorectral /Medical Due to (or as a consequence of) Examiner with G DAYS I JURY MIDICAL EAO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner sician and burial-transit Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical 20, Led IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 ☐ Ectopic pregnancy in the past 12 months? 1☐Yes →2☐No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 I Inknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 s autopsy certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Sinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Yes 2□ No funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 8/14/2007 Ham 4 1 ☐ Yes 2 No PATIENT death. PH FELL AT Phospital or Attendle 24 hours after death.
Funeral Director: A 2 Accident 6 ☐ Could not be 3☐ Suicide Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 ☐ Homicide 357 PAW PAW west RES (PENCE 24 hours a 🔽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 24 To the I 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 81 nRan 20 00065700 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32/ Registrar's Sign 31. Date filed (Month, Day, Year) State

Registrar

AUG 2 8 2007

			For State Registrar	State of	Maryland		artment tificate			ind M		leg. No.		27	592
П	Physicia	an	Decedent's Name (First, Middle,								Date of Dea Month	ith Day	Yea		e of Death
,	/Medic		Eleanor Brauch			-					08/13/				00 ^{P M}
	Examin	er	4a. Fecility Name (If not institution,	give street and num	ber)		4b. City, 1	fown, or	Location o	f Death			County of De	ath	,
			Heron Point 5. Social Security Number	S. Sex	7. Age (In yrs. la	ast hirthday)	Che If Under		town	24 Hrs.	8. Date of Birth	1	ent 9 B	intholace (Sta	ate or Foreign
4	Funeral Director		215-38-4322	1 □ M 2 🖫 F	90	Yrs.		Days	Hours	Min.	7/6/191	Year)	MN	Country)	it or or oronger
			Usual Residence of Decedent												
	show	_	10a. State 10b. County		1	, Town or La									le City Limits Yes 2 \(\subseteq No
	8a-f	Scto	MD Kent		Che	estert									
	with th	吉	10e. Street and Number				10f. Zip						zen of What	country?	
	eath is 23	eral	491 Cormorant (dent Ever in U.S	5 13 1	216		snanic Orig	nin? (Sne	ecify Yes or No-	USA	A 14. Race - Ar	nerican India	n.
	r Iten	by Funeral Director	1 Never Married 2 Marrie	Armed For	ces?		f Yes, spec	rfy Cuba	n, Mexican	, Puerto	Rican, etc.)		Black, Wi	iite, etc.	.,
<u> </u>	al', o	þ	3X Widowed 4 □ Divorced	d 1 ☐ Yes If Yes, Give Year or Da	tes:		1 ☐ Yes 2	No 🟋	Specify:				Specify: W	hite	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or flems 23a or 28a-f show ther the Medical Examinat must be notilled at	Completed	15. Decedent's (Specify only highest			16a. Deced	dent's Usua kind of wor	l Occupa	ation during most	t of work	ina	16b. Kir	nd of Busines	s/Industry	
7	ithin hen.	npi du	Elementary/Secondary (0-12)	College (1	4or 5+)	life.	oo NOTus arian	e retired)			I.i.	teratu	re	
2	filed withi Hygiene. other then	S	17. Father's Name (First, Middle, L.	4	1	TIDI		T	18 Mothe	r's Name	e (First, Middle,				
auc	0 = 0 >	Be c		301/							h Achenl		ourname)		
Maryland	2 should be filed within 72 hours after death with the Marylar and Mental Hygiene . is marked other than "natural", or items 23a or 28a-f show armstic event, the Medical Examinar must be notilied at	ဥ	John Brauch 19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Address	(Street a			al Route Numbe		r Town, State	, Zip Code)	
	nd 2 ;		Karin Peterson/D			21 R	obin	Rd.	West	Ha:	rtford,	CT	0611	9	
Baltimore,	of Heal		20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Nam	e of	e)	[Date	20c. Lo	cation - City	or Town, Stat	9
E	Pages nent of int: If its iry or o		1 ☐ Burial 2 ♣ Cremation : 4 ☐ Donation 5 ☐ Other (Sp.		Male	sapeak				8/1.	5/07	St	evensv	ille,M	Œ
a	permit. Pages 1 and 2 should b Department of Health and Ments Important: If Item 27 is marked any Injury or other traumatic e once.		21. Signature of Funeral Service L	gensee /						yFe1	lows,Hel	lfen	bein &	Newna	ım
<u></u>	9.07 2 2 3		* Kuk ggl	Gerber	J						ertown,1		1620	_	
			23a. Part 1. Enter the disease, or o shock, or heart failure. List o	nly one cause on ea	ich line.	^		of dyin	g, such as	cardiac	or respiratory ar	rest,			imate I Between and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	-a PN	EUMO	NIA	_							Ide	ay
×.	/Medical Examiner		resulting in deality	Due to (or as a consequ	uence of):)
	3-3	-E	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a consequ	uence of):	-								-
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	4										4	
o,	an an rial-tr	Exa	resulting in death) Last	Due to (or as a consequ	uence of):									
3760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Icai		d.											
<u> </u>	eath certifics attending ph i for use as ti	Physician/Med	IF FEMALE:	00. 1/											
Вох	ath c attenc for us	ian/	23b. Was decedent pregnant in the past 12 months?		rth 2 ☐ Fetal ant at time of de	death 3[Ectopic pre					2	23d. Date of o Month	lelivery Day	Year
o.	the de	ysic	1 ☐ Yes 21 No 9 ☐ Unknown	9☐ Unkno		atin 5	Other (spe	9CIIY)							
٥.	res that the de signed by the a be detached f		Part II. Other significant condition					ause give	en in Part I.		23e. Did to	obacco u	se contribute	to the cause	of death?
rds	v requires been sign should be	ed by	CHRONIC LYMP	140CL+1C	LEH	KEMI	A				1 🗆 Y	es 2	XNo 3□	Probably	4 □Unknown
Records,	s bee	plete	SEVERE, GE	UERAL	FRAI	LTY					24a. Was		24b. Were	autopsy find	ings available
	Physician: The lav this certificate has al director, page 2	Completed	RHEUMATOIN	ANTH	RITIS						autop perto: 1 Yes	rmed? 2 X No	death	o completion?	OI Cause OI
ita	stan: artifica ctor.	Be C	25. Was case referred to medical examiner?						26. Place	of Deat	h (Check only o				
Division of Vital	Attending Physician: if death. ector: After this certification in the funeral director.	2	1 ☐ Yes 2 No			ER/Outpatier		THE REAL PROPERTY.	4 1000	-	me 5 Resid			pecify)	
U.	l or Attending Patter death. Director: After t	ion:	27. Manner of Death 1 Natural 5 ☐ Pending		of Injury h, Day Year)	28b. Time o Injury		8c. Injun Wor			28d. Describe I	now injur	y occurred		
S	death death stor:	icat	2 Accident investigation inves	ot be 200 Binon	of Injury - At ho	me farm st	M factory		Yes 2	NO	28f. Location (S	Street an	d Number or	Rural Route	Number
<u>></u>	after Direction by	Certification:	4 Homicide determin	buildir	ng, etc. (Specify	()	oot, lactory	, omes			City or Tov				, ,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier Certifying	Physician: To the	best of my know	wledge, deat	h occurred :	at the tim	ne, date an	d place,	and due to the	cause(s)	and manner	as stated.	
	he Hc in 24 ha Fu pletely	edical	(Check only 2 Medical E	xaminer: On the ba and mann	isis of examinat	tion and/or in	vestigation,	in my o	pinion, dea	th occur	red at the time,	date and	place, and o	ue to the cau	use(s)
	To the comp	Ž	29b. Signature and title of certifier	111	7 0		1		a number	/		29d. Dat	e signed (Mo	nth, Day, Ye	ar)
	3		Aul	t M	Mh	M		1)	0041	128	/	7	113	1200	7
			30. Name and address of person w		~										
W.	My		31. Date filed (Month, Day, Year)	122 Sp	egistr s Signa	ture C	hest	ct	200	, v	S G	167	0		
	Sta Registi			1 4 2007	A	0		16							

DHMH 17 Rev 1/2001

07-06	3402
Glon	Polk

Blen Polk .		State of Maryland / Department of -For State Certificate of			J. No. 200	7 2759
Physician Medical Examine	/ 1	I. Decedent's Name (First, Middle,Last)		2. Date of Death	Day Year	3. Time of Death 1448 hrs
The state of the s		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Deat	h
1	_	404 Lake Street 5. Social Security Number	Salisbury If Under 1 Year If Under 24Hr	n I Poto of Birth	Worcester	rthnlace (State or
Funeral Director	6	214-70-5235 1×M 2 F 51 Yrs	Months Days Hours Mir	1	Forei	gn puntry) MD
and the second	~	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locat	tion	· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits
*	5	MD WICDMICD SALIS 10e. Street and Number	BURY	X		1 Yes 2 No
the Maryland a or 28a-f sh Uffed at once	3 7			. 10	9. Citizen of What Cou	intry?
with the Maryland ns 23a or 28a-f sho be notified at once.	<u> </u>	404 - LAKE ST. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	2/80[as Decedent of Hispanic Origin? (§	Specify Yes or No-	0 /	rican Indian, Black,
or death with or items 23.			Yes, specify Cuban, Mexican, Puert		White, etc.	
s after raff, o	3	3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 No specify: nt's Usual Occupation (Give kind of	work done	Specify: R	
2 hour "natu	Completed		nost of working life. DO NOT use re			7
5-0036 led within 7 Hygiene. other than the Medic			ISTODIAN		Joller	ROGERS
1215-0036 Id be filed within 72 fental Hygiene. narked other than event, the Medical	20	17. Father's Name (First, Middle, Last)	18.Mother's Nam	ne (First, Middle, M	laiden Sumame)	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Healing Manual Hygiene. Intelligent 7 is marked other than "natural", or items 23a or 28a-fath on other traumatic event, the Medical Examiner must be notified at once To-Do Completed by Eringeral Director		Trans.	ng Address (Street and Number or	Taranta Anna		
ore, MD 2 ss 1 and 2 shoul of Health and N if item 27 is in ner traumatic		TVA P. BROCKEN - MOTHER 260, 200. Method of Disposition 200. Place of Dispo	II-WALNUT TRE	EKDE	20c. Location - City of	21822 or Town, State
altimore, mit Pages I ar epartment of He nportant: If ite		1 Rurial 2 Cremation 3 Removal from State crematory or of	ther place)	(()	DELM	10 DE
Baltimore permit Pages 1 Department of F Important: If injury or other		4 Donation 5 Other Specify: REMAIOR 21. Signature of Funeral Service Licensee 2	Name and Address of Facility	SENNIE	SMITH F	UN ERAL HOME
0 80 5 5	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter	17-WISABEU	LA STS	ALISBURY.	Mp 21801 Approximate Interval
Physician /Medical	1	failure. List only one cause on each line.				Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hyrertensive cardiovasculure to (or as a consequence of):	Lar disease complica	red by bypa	21816 2011 2	
	ا _ة	Sequentially list conditions, if any, leading to humodate the force a consequence of:	,			
		cause. Enter Underlying Cause (Disease or injury that initiated				
cuted nd transit	Ľ	events resulting in death) Last Due to (or as a consequence or):				
D, be exe sician a	edical	X UNPENDED #MENDED, 28a-f, perME, g87	1, 9/27/07 TT			_
876 tificate ng phy as the t		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 F	etal death 3 Ectopic preg	nancy	23d. Date of delive Month	Day Year
ox 6 eath cer attendi	Physician/N		Other (Specify)			
		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		bacco use contribute	
n of Vital Records, P.C. ing Physician: The law requires that After this certificate has been signed funeral director, page 2 should be deter	ed by			-	2 V No 3 P	
aw requals bee	ompleted			24a. Was a autop perfor		autopsy findings available ocompletion of cause of
Rec	ပ	25. Was case referred to medical	26.Place of Death (Chec	1 Yes	2 No 1 🗸	Yes 2 No
Vital ysician ysician directo	e Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier	Other:		Residence 6 🗸 Otl	ner: Scene
ing Ph After t funeral		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of			how injury occurred	
Sior Attend r death ector: by the	g	2 X Accident Investigation Fnd 8/18/2007 Fnd 2:4			very warm er	NITONMENT Rural Route Number, City
Divi	Certification:	3 Suicide 6 Could not be determined (Specify) house		404 Lake	State) St. Salisbur	y, MD
	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occ one) 2 Medical Examiner: On the basis of examination and/or investig		ind due to the caus	se(s) and manner as s	ated.
T Wight	Š	29b. Signature and title of certifier	29c. License number		29d. Date signed (/	
GAL		Wanter The Youll	O.C.M.E.		August 19, 200)/
700		30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111	Penn Street, Baltimore, Mi	D 21201		
Sta	ite	31. Date filed (Month 1992 Year) 2007 32. Faistrar's Signature	P. W.			
Registr	ar	Weller D.				

	1- For Amend Items 24a,25 per dr.	d / Sop a fgroß / Mari th and l Certificate of Death	Mental Hygiene Reg. No	007 27591
	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	3. Time of Death
Physician /Medical	Mildred Elizabeth I	Pusey	August 9,	2007 4:37 M
Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	n 4c. 0	County of Death
	33639 Rohm Road 5. Social Security Number 6. Sex 7. Age (In yrs.	Parsonsburg (last birthday) If Under 1 Year If Under 24 Hrs.		icomico
Funeral Director	218-20-6423 1 M 2 S F 80	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 12/13/1926	Birthplace (State or Foreign Country) Maryland
Du 🔻	Usual Residence of Decedent 10a. State 10b. County 10c. Cit	y, Town or Location	10/10/10	10d. Inside City Limits
Aaryla				1 Yes 2 XNo
the h	Maryland Wicomico Pa	arsonsburg 101. Zip Code	10g. Citiz	en of What Country?
3a or	33639 Rohm Road	21850	US	A
eme :	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No- 1- o Rican, etc.)	4. Race - American Indian, Black, White, etc.
21215-0036 ed within 72 hours after death with the Mar Vojene. her than "natural", or Iteme 23a or 28a-f ele it, the Madical Examinar must be notified Completed by Funeral Director	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: white
2 hours	15. Decedent's Education	16a. Decedent's Usual Occupation	16b. Kin	d of Business/Industry
21215-0036 bd within 72 hours att giene. er than "natural", or than Madical Exami than Madical Exami	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+)	(Give kind of work done during most of wor life. DO NOT use retired)	rking	
led will yajien her th.	10 -	Bottler		erage Company
Maryland 21215-0036 Id 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 le marked other than "natural", or Iteme 23s or 28s-f show traumatic event, it a Madical Examinar must be notified at To Be Completed by Funeral Director	17. Father's Name (First, Middle, Last) unknown		ne (First, Middle, Maiden S Layfield	Sumame)
rryla should in marke maric of	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Ru		Town, State, Zip Code)
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryla if Healin and Mental Hygiene. The marked other than "natural", or Items 23a or 28s-1 shoother traumatic event, the Marked Exam mermual the notified at To Be Completed by Funeral Director	Lola M. Campli/daughter	13601 Sand Dune Rd.		
Baltimore, sermit Pages 1 ar Separtment of Hes mportant: If Item nay injury or othe bace.	20a. Method of Disposition 20b. P	lace of Disposition (Name of emetery, crematory, or other place)	Date 20c. Loc	ation - City or Town, State
Itim it. Pag rtmeni rtant: njury	4 Donation 5 Other (Specify) 21. Specific of Funcial Service License	Gardens 8/13		ron, MD
Baltimore, Mapermit. Pages 1 and 2 s Department of Health an Important: If I tem 27 le eny injury or other trau	on to	²² Name and Address of Facility HOIIOWAY Funeral 501 Snow Hill Rd.	Home Profess, Salisbury,	ional Association MD 21804
	26a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.			Approximate Interval Between
Physician	Immediate Cause (Final disease or condition			Onset and Death
/Medical Examiner	resulting in death) Due to (or as a consequ	uence of):		
Jer Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	uence of):		
35 W; 8760, cate be executed physician and it the burial-transit dlcal Examiner	that initiated events			
60, 60, be exe cician a burial-	resulting in death) Last Due to (or as a consequ	uence of):		
68760, ficate be e. physician is the buria	d			
Box 6 Box 7 Box 6 Box 7	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregna		23	3d. Date of delivery
S, P.O. Box 6 so that the death certification goed by the attending be detached for use as by Physiclan/Me	In the past 12 months? 1 Ves VNo 4 Pregnant at time old of the past 12 months?			Month Day Year
P.O. P.O. d by till letach	9 ☐ Unknown Part II. Dther significant conditions contributing to death but not resi	deine in the conduction of the conduction	22a Did tabasas va	e contribute to the cause of death?
Vision of Vital Records, P.O. Box 6 Attending Physician: The law requires that the death certificate has been signed by the attending by the funeral director, page 2 should be detached for use as iffication; To Be Completed by Physician/Me	Tach. Step significant conditions contributing to death but not rest	oning in the underlying cause given in Fait i.		No 3 Probably 4 Junknown
Division of Vital Record or Attending Physician: The law requir after death. Director: After this certificate has been sit in by the funeral director, page 2 should be etitification; To Be Completed			24a. Was an	24b. Were autopsy findings available prior to completion of cause of
II Rec The lav sate has page 2			autopsy performed?	prior to completion of cause of death? 1 □ Yes 2 □ No
f Vital F ysicien: Th ysicien: Th lis certificate director, pag	25. Was case referred to medical examiner?	26. Place of Dea	ath (Check only one)	
Physic this coal direction of To it	1 ☐ Yes 2 Xio Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DOA Other. 4 Nursing H	ome 6 Residence 6	Other (Specify)
on of ding Phy. After thi funeral funeral funeral ton; T	27. Manner of Death ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation 2 ☐ Accident investigation	28b. Time of Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred
/iSicalent Attender respectively the	3 Suicide 6 Could not be determined 28e. Place of Injury · At ho	ome, farm, street, factory, office	28f. Location (Street and	Number or Rural Route Number,
Division c tal or Attending P rs after death. Tal Director: After t led in by the funera Certification;	4 Homicide determined building, etc. (Specify	<i>(</i>)	City or Town, State)	
Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the th Medical Certificati	29a. Certifier Certifying Physician: To the best of my kno (Check only one) 2 Medical Examiner. On the best of examinal and manner stated	wledge, death occurred at the time, date and place tion and/or investigation, in my opinion, death occu	e, and due to the cause(s) a irred at the time, date and p	and manner as stated. Diace, and due to the cause(s)
To the mithin 2 Co the comple	29b. Signature and title of certifier	29c. License number		signed (Month, Day, Year)
	Mento, M.O.	D 0063199	. 0	8/10/2007,
10/4	30. Name that a dress of person who completed cause of death (Item YOGESH VOHRA 614 EAST	23a) (Type, Print) ERN SHORE DR., SALI	SBURY, ME	21804,
State Registrar	31. Date filed (Month, Day, Year) AUG 1 4 2007 32. Brigistrar's Signa	(23a) (Type, Print) ELN SHOLE DR., SALI ture H. Annall.		

			1 - For State Registrar	State of Ma	ryland / De _l . <i>Ce</i>	partment of e <i>rtificate o</i> a	Health a f <i>Death</i>	and M		iene 2 og. No.	007	2/59.	
	Physici	an	Decedent's Name (First, Middle, Last)						2. Date of Death Month		2007	3. Time of Death	
ì	/Medic	cal	Janet Mae Row 4a. Facility Name (If not institution, give stre			4b. City, Town	or Location o	f Death	Aug		ty ol Death	3:10 P M	
	Examin	ner	Beverly Living Cent			40. Oity, 10mil	Hagers		1		shingt	ton	
	Funeral Director		5. Social Security Number 6. Sex		(In yrs. last birthda 81 Yrs.	y) If Under 1 Yea Months Day	r If Under 2		8. Date of Birth Month, Day, Dec 24,			olace (State or Foreign ntry) PA	
	pur »		Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Town or	Location						10d. Inside City Limits	
	Maryli	Į.	MD Washingt	on		lagerstow	n					1 X Yes 2 □ No	
	or 28a	lrec	10e. Street and Number							0g. Citizen o	Citizen of What Country?		
	23a c	raiD	750 Dual Highway					740			USA		
0000	ges 1 and 2 should be filed within 72 hours after death with the Maryland to fleatin and Mental Hygiene. It of Heatin and Mental Hygiene. or other traumatic avant, the Madical Examiner must be notified at	by Funeral Director	11. Marital Status 1 [X] Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		3. Was Decedent of If Yes, specify Control of Italian (1997). 1 ☐ Yes 2 🗓 N		gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		ace - Americ ack, White, ify: Wh		
5	2 hou		15. Decedent's Educat	ion	16a. De	cedent's Usual Occ ve kind of work dor	upation	of working		16b. Kind of	Business/In	dustry	
7	ithin 7	Completed	(Specify only highest grade c	College (1-4or 5-	life	Disabled	red)	Or WOIKII	,y				
7	filed w Hygiei ther ti		10 17. Father's Name (First, Middle, Last)			DISAULEG	18. Mothe	r's Name	(First, Middle, A	Maiden Surna	ame)		
2	id be ental ked o ic ave	To Be	Ralph L. Rowe						ımbaugh		,		
a y	shou and M	-	19a. Informant's Name/Relationship (Type,	. Print)		iling Address (Stre							
,, E	and		Patricia Blount	sister		Mount V	ernon '						
5	Pages 1 nent of H int: if ita iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem	noval from State	cemetery, c	position (Name of rematory or other p		_		20c. Location		own, State PA 17268	
			4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee										
Ď	permit. Departr Imports any inje		James G. Bay	busan	- 9	50 S.	Broad :	St.,	Waynesb	oro,	PA 172	l Home, Inc 268	
	Physician Addical Medical Medical Medical Examiner Itausit Ita	dical Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to ministrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a	consequence of): consequence of):	TRUCTIL	16 P	ULI	10HAR	~ D	5 5/15	Initerval Between Onset and Death	
.C. DOA 00	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To tha Funarei Director: Attent his certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown				23d. Date ol delivery Month Day Year						
corus, r	quires that in signed b uld be detz	٥	Part II. Other significant conditions contri HYPERT &	ditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did to						tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknow			
7	The law re ate has bee page 2 sho	Completed						_	24a. Was an autops perform	v	D. Were auto prior to co death? 1 \(\text{Yes}	opsy findings available ompletion of cause of	
N I I	ician: sertific ector.	Be (25. Was case referred to medical examiner?	nital:				of Death	(Check only on	e)			
5	ding Physi h. After this c funeral dir	tlon: To	27. Manne of Death 1 Natural 5 Pending	pital: 1 ☐ Inpatier 28a. Date of Injun (Month, Day		of 28c. In		2	ne 5 Reside			fy)	
DIVIS	al or Atten s efter deat st Directors d in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide 1 Homicide 28e. Place of Injury - At home, Iarm, street, Iactory, office 28l. Loca building, etc. (Specify)							reet and Nur 1, State)	nber or Run	al Route Number,	
	he Hospit in 24 hour. he Funere pletely fille	edicai	29a. Certifier Certifying Physic (Check only one)	ian: To the best of r: On the basis of and manner sta	examination and/or	ath occurred at the investigation, in m	time, date and opinion, deat	d place, a	and due to the ca	ause(s) and i ate and place	manner as s e, and due t	stated. o the cause(s)	
	To t To t	×	29b. Signature and little of certifier		MD	29c. Lice	D U U	42	327	9d. Date sign	red (Month,	Day, Year)	
	2		30. Name and address of person who com	T. 1	1Abel	e, Print)	M	P	217	40	Rena	Bansil	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 8 2007	32. Registra	r's Signature	andes							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Degedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death **Physician** 3:25 PM /Medical Mown, or Location of Death Facility Name (II not institution, give street and number) 4c. County of Death Examiner If Under 24 Hrs. 8. Date of Birth
Hours | Min. (Month, Day, Year) Security Number 7. Age (In yrs. last birthday, Year Birthplace (State or Foreign Country) **Funeral** Days Months 1 🖾 M 2 🗆 F 179-16-9152 Yrs 85 Director 9/28/21 PA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Ex miner must be notified at 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Director MD Kent Rock Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5795 Chesapeake Villa Rd. 21661 USA Funeral 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?
1 X Yes 2 □ No Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Completed by If Yes, Give 10/3/42— Year or Dates: 11/19/45 Specify: Specify: White 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) **Building** Stair Builder 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur Simes Rann Bessie Walch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Porter/Personal Rep. 5175 Edesville Rd. Rock Hall, MD 21661 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Cremation Ctr. 08/11/07 Stevensville,MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Rd. Chestertown, MD 21620 Approximate Interval Between Onset and Death art1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. ing, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) Humon, **Physician** /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusc to for an э пользаиворы off Examiner be executed burial-tra Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical death certificate IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 Ves 2 No the o 9 Unknown signed by t σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No. 24a. Was an page 2 has autopsy performed 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 1 Inpatient this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: After 1 Division (Month, Day or Attending 1 ☐Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours after the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatui

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State Registrar

Name and

31. Date filed (Month, Day, Year) AUG 1

MICENTE

MEL MY 32. Register's Signature

2007

completed cause of death (Item 23a) (Type, Print)

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SEES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 10 200) Robinson Pau1 John /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Wiczmico Kegisnal Medical Cerder Alisbure If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Funeral Min. Months Days Hours 1 X M 2 □ F South Dakota 04/09/1936 71 226-42-9327 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ar than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Princess Anne MD Somerset 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 21853 USA 10455 Blue Bird Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 1956-58 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify Baltimore, Maryland 21215-0036 Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Department of Health and Mental Hygienes important: If Item 27 is marked other than any injury or other traumatic event, the Me once. College (1-4or 5+) Trucking Company Truck Driver none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marguerite Chaussee Paul John Robinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11026 Harry Riggin Road, Princess Anne, MD 21853 Martha Robinson/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 08/13/2007 Salisbury, Maryland Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) ignature of Funer Service Licenses 22 Name and Address of Facility Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, MD 21853 2 ia. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) Ven Physician /Medical Due to (or as a consequence of) Examiner roce Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **∂** 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2□No 1□ Yes 2□No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner Teath Hospital 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

State

31. Date filed (Month, Day, Year) AUG 15 2007

and title/of certifier

29a. Certifier

one)

29b. Signatur

Medical



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 25036

614 EAJTEAN SHORK DRWE. SALISBURY

29d. Date signed (Month, Day, Year)

8/11/07

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Aug 19, 2007 **Physician** 2:30AM Sheehe /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cumberland Allegany Country House Residence If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb 26, 1915 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔀 F 217-30-2130 Director 92 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatith and Mental Hygiene.

nt: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Allegany 1 Yes 2 No MD Cumberland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 15 Cumberland Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Xo Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 X Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Department nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Briget Marshall Abele Romanus Abele 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
35871 Spinnaker Circle Lewes DE 19958 19a. Informant's Name/Relationship (Type. Print) Mary Beth Merolla daughter Place of Disposition (Name of cemetery, crematory or other place)
 St. Mary's Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 8/22/2007 MD Cumberland 4 □ Donation 5 □ Other (Specify) 21. Signature of uneral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Eart1. Finter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician lears disease or condition resulting in death) /Medical (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ □ □ 24a. Was an certificate has tirector, page 2 s autopsy performed? Yes 224No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTED 1 ☐ Yes 2 ☐No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this After this funeral of 27. Manner of Math 1 Matural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Funeral I 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of cortifier 29d. Date signed (Month, Day, Year,

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State Registrar HUMA SHAKIL

31. Date filed (Month, Day, Year)

AUG 2 8 2007

DHMH 17 Rev 1/2001

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CUMBERUND, MD 21502

MD

625 KENT

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** 12, SCHWARTZBECK AUGUST 2007 12:32P /Medical DAVID 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Social Security Number 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F 214-12-0984 85 1922 Director MAR 4 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director MD 1 Yes 2 □ No FREDERICK FREDERICK 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2 should be filed within 72 hours after death with 1 1 and Mental Hygiene. Is marked other than "natural"; or items 23a or 2 2137-BC WAINWRIGHT CT. 21702 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Amed Foces: 1 Mg Yes 2 □ No 1942 – If Yes, Give Year or Dates: 1947 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: à WHITE 3 MWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry BUILDING SUPPLY Elementary/Secondary (0-12) College (1-4or 5+) MANAGER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) GEORGE BAUGHMAN SCHWARTZBECK SARAH ELIZABETH ROBERTS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20814 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health as Important: If Item 27 is any injury TOM SCHWARTZBECK / NEPHEW 10521 AUBINOE FARM DR., BETHESDA, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) PARKLAWN CEMETERY 8/16/2007 ROCKVILLE, MD 21. Signature of Juneral Jervi & Lensee 22. Name and Address of Facility HILTON FUNERAL P.O. BOX 86, B 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GASTRO INTESTINAL 4 DAYS **Physician** HEMORRHAGE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-trar Due to (or as a consequence of) physician Physician/Medical the as 1 the attending IF FEMALE: nse i 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 1 Yes 2 No 3 Probably 4 Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an has page 2 autopsy certificate 1□ Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation

be executed Box 68760, Ö ٦ Division or Vital Records, After this s after dea... filled in by ō

altimore, Maryland 21215-0036

and 2 should be

Certification:

within 24 hours at To the Funeral D Hospital

Registrar

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6 Could not be determined

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. DANKLSON MA & SC THOMAS

THOMAS

JOHNSON DR FREDERICK 2:702

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

2 Accident

3 Suicide

29a, Certifier (Check only

one)

4 Homicide

32. Registrar's Signature

and manner stated.

2007 ▶

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

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	Examir		4a. Facility Name (If not institution, gi	ve street and number	er)		4b. City, To	wn, or	Location of Death		4	c. County	of Death		
			Northampton Manor				Frede					rede			
	Funeral			Sex 7. 1 ☐ M 2 🔀 F		last birthday) Yrs.	If Under 1 \ Months E	Days	If Under 24 Hrs. Hours Min.	8. Date of B	ay. Year	2,0	Coul		
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<u>a</u> n	id be ental ked c	To Be	Andrew Leahy Nori	ric					Alice Is	ahalla	Kic	ner			
Maryland 21215-0036	shound M	-	19a. Informant's Name/Relationship			19b. Mailir	ng Address (S		and Number or Run				State, Zip	Code)	
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Baltimore,	of He of He item		20a. Method of Disposition		20b. F	Place of Dispo cemetery, crer	sition (Name matory or othe	of or place	9)	Date				own, State	<u> </u>
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Vital	icien: Th certificete rector, pag	Be	25. Was case referred to medical examiner?						26. Place of Deat						
of	Physi this c	P	1 Yes 2 No			ER/Outpatien		Othe	4.M. Nursing Ho					fy)	
	ttending Physicien: death. stor: After this certific the funeral director.	lo	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of I (Month,	Day Year)	28b. Time of Injury	M 28c.	. Injury Work		28d. Describe	now inj	ury occur	red		
Sign	death death ctor: A	cat	2 Accident investigate 3 Suicide 6 Could not	be Ope Diese of	Injury - At h	ome, farm, str			res 2 □ No	28f Location	(Street s	and Numb	or or Run	al Route Numb	201
Division	or A efter Dire	Certification:	4 Homicide determined	building,	etc. (Specil	fy)	eet, ractory, o	niice		City or To			707 07 71076	ar / 10010 / Voillo	·6/,
	Hospital		29a. Certifier Certifying P	hysicien: To the be	est of my kno	owledge, death	h occurred at t	the time	e, date and place.	and due to the	e cause(s) and ma	anner as s	stated.	
	P Ho	edical	(Check only 2 Medical Exe	miner: On the basis and manner	s of examina	ation and/or in	vestigation, in	my op	pinion, death occur	red at the time	, date a	nd place,	and due to	o the cause(s)	
	To the Hospital or Attending Physicien: The law within 24 hours efter death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2	Me	29b. Signature and title of certifier	1 -	MA		29c. L	icense	number		29d. D	ate signe	d (Month,	Day, Year)	
			→	The same	1111)	•	D54	636	5		Δ110	1121	15, 2	2007	
	P		30. Name and address of person who	completed cause of	of death (Iter	m 23a) (Type,					_i.ug	406	2 ور.		
_			Syed W. Haque, MI	, 700 Men	itclai	re Ave	nue Fi	red	erick, Ma	aryland	217	01			
	Sta		Syed W. Haque, MD 31. Date filed (Month, Day, Year) AUG 15	2007 32.	istrar's Signa	15 P									
	Registr	ar	HUU T			•									

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23 or 28a-f show eny liutry or other traumetic event, the Medical Examiner must be natified at education.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, State

1 - State Registrar		Ce	rtificate of	Death		Reg. No.				
1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death			
Billy Ri	.chard	Stephen	S		August		7 12:45 A			
4a. Facility Name (If not institution, give st	treet and number)		4b. City, Town, o	r Location of Death		4c. County of I	Death			
909 Emerald Court			Salisbu	ıry		Wic	comico			
210 30 3001	M 2□F 7. Age	(In yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)	Birthplace (State or Foreign Country) (aryland			
Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits			
							1 X Yes 2 □ No			
Maryland Wicomico)	Salisbury	10f. Zip Code			10g. Citizen of Wha	10			
909 Emerald Court			21804	1		USA	it Country?			
11. Marital Status	2. Was Decedent E	ver in U.S. 13		Hispanic Origin? (Sp	ectly Yes or No-		American Indian.			
Maryland Wicomico 10e. Street and Number 909 Emerald Court 11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) William Albert Ste	Armed Forces? 1 ☐ Yes 2 ☑N If Yes, Give Year or Dates:	0	If Yes, specify Cub 1 ☐ Yes 2 X No	an, Mexican, Puerto Specify:	Rican, etc.)		White, etc. white			
15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece	dent's Usual Occu	pation during most of work	ina	16b. Kind of Busin	ess/Industry			
Elementary/Secondary (0-12)	College (1-4or 5-	+) /ife.	DO NOT use retire	d)						
12	4	Manuf	acturing	Superviso		E.I. Du	Pont Co.			
17. Father's Name (First, Middle, Last) William Albert Ste	ephens			18. Mother's Name Martha		irst, Middle, Maiden Sumame) aylor				
19a. Informant's Name/Relationship (Typ	e, Print)	19b. Maili	ing Address (Street	and Number or Run	al Route Numbe	er, City or Town, Sta	ite, Zip Code)			
Carol Kay Stephens	s/wife			Court, Sa		, MD 2180	04			
20a. Method of Disposition 1 **\frac{1}{2}*\text{Burial} 2 **\text{Cremation} 3 **\text{Pecify}\) 4 **\text{Donation} 5 **\text{Other} (Specify)	emoval from State	20b. Place of Dispo cemetery, cre Hebron C	matory`or other pla		Date 5/07	20c. Location - Cit				
21. Signature of Funeral Service License	θ	2								
Shapping 10	momo	CFSP	28178MSA	HITTERA.	lowe Pre	iessima.	Association			
Immediate Cause (Final disease or condition resulting in death) Seguentially list conditions,	Due to (or as a	a consequence of):	EROTIL	HEART	DISE	MSE	YEARS			
of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c.		a consequence of):								
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence or).								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 1 4 □ Pregnant at 1 9 □ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date o Month				
Part II. Other significant conditions cont						obacco use contribu	ute to the cause of death?			
CHRONIC OSS					ر ا ا ا	Yes 2 □ No 3[Probably 4 Dunknown			
ATRIAZ FIRA	RILL ATTE	200				osy prio ermed? dea	re autopsy findings available in to completion of cause of th? Yes 2 □ No			
25. Was case referred to medical				26. Place of Deat	12. 7		103 20110			
examiner?	ospital:	nt 2 ER/Outpatie	ent 3 DOA Ot	ner: 4 🗆 Nursing Ho		dence 6 Other	(Specify)			
1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide 6 Could not be 4 Homicide 12 Pentityin Physical Examination	28a. Date of Injur (Month, Day	Year) 28b. Time of Injury	of 28c. Inju			how injury occurred				
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	iry - At home, farm, st (Specify)	treet, factory, office		28f. Location (: City or Tou		or Rural Route Number,			
29a Cerifier 1 Phys. (Check only 2 Medical Examin one)	ician: To the best of er: On the basis of and manner sta	of my knowledge dga examination and/or in ted.	th occurred at the to nvestigation, in my	ing date and place, opinion, death occur	trid due to the red at the time,	causc(s) and mann date and place, and	of 35 stated d due to the cause(s)			
29b. Signature and title of certifier	~ /	NO	29c. Licen	se number 26 29/6		29d. Date signed (1) AU6437	Month, Day, Year)			
30. Name and a ress of person who con	mpl ed cause of de	eath (Item 23a) (Type	Print)	SHITE !	3 SA213	(Bury A	10 21804			

Registrar

31. Date filed (Month ADG Year) 4 2007

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 08/15/07 **Physician** 2200 Martha Grace Stock /Medical a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chester River Hospital Center Chestertown Kent If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 02/15/17 Birthplace (State or Foreign Country)
 PA 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 194-16-7088 90 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 □ No **Funeral Director** MD Worton Kent 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 12784 Coopers Ln 21678 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Martin Martha Gibbs ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin Stock/Son 12784 Coopers Ln Worton, MD 21678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) n Cemtery 08/20/07 Clarksboro NJ 22. Name and Address of Facility ellows, Helfenbein & Newnam Eglington Cemtery 21. Signature of Funeral Service Licensee 130 Speer Rd. Chestertown, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) virolem **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown tributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes 2 No 1 Inpatient ٩ 2 ER/Outpatient 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Naturai 5 Pending investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I the certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29b. Signature 1060301 ath (Item 23a) (Type Prin 30. Name and address of person v ha completed cause 6) MON MICHAGI 31. Date filed (Month, Day, 32. Regis Registrar

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: nours after death.

neral Director: After this

filled in by the funeral d

State Registrar

Medical

29a. Certifier

29b. Signature

Certifying Physi

larcallis

3 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

manner stated.

3169

n: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Omphe basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death AUGUST 11, 2007 ear VERDELLA MARIE SHORT 8:15 A M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death GENESIS ELDERCARE CENTER LA PLATA CHARLES If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 83 217-28-8014 SEPT. 24, 1923 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 □ No CHARLES INDIAN HEAD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 120 WOODLAND DRIVE 20640 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedon. _ Armed Forces? 1 □ Yes 24 No Black, White, etc. ☐ Yes 2 Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: BLACK If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DIETICIAN HEALTH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) THOMAS KEY JANE ELEANOR SCOTT KEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IGENE COOPER/DAUGHTER 683 PISCATAWAY CT., LA PLATA, MARYLAND 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State METROPOLITAN METH CHICEM 8/16/2007 INDIAN HEAD, MD 4 ☐ Donation 5 ☐ Other (Specify) of Puneral Arvice by my 22. Name and Address of Facility THORNTON FINEAL HOME P.A. 3439 LLVINGSTON ROAD, INDIAN HEAD, MD 20640

Hypertension

3 Ectopic pregnancy

5 Other (specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a, State

MD

Director

Funeral

Completed by

Be

ဥ

Funeral

Director

within 72 hours after death with

d 2 should be filed within ? th and Mental Hygiene. **7 is marked other than "**!

of Health

Baltimore, Maryland 21215-0036

anding physician and use as the burial-transi signed by the a To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral director. After this

P.O. Box 68760,

Division or Vital Records,

certificate be

Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Iter
any injury or ott Examine Physician/Medical IF FEMALE þ Certification:

LIDIA C. THORNTON JOHNSON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25. Was case referred to medical examiner?

27. Manner of Death
1 Natural
2 ☐ Accident

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 18 months? 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic

3 Suicide 4 ☐ Homicide

29b. Signature and title of certifier

29a. Certifier

5 Pending investigation 6 ☐ Could not be

determined TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

disease

Due to (or as a consequence of):

Due to (or as a consequence of)

Due to (or as a consequence of):

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

9□Unknown

KIDNRY

Hospital:

4□Pregnant at time of death

Injury at Work? 1 Yes 2 No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number 20061616

29d. Date signed (Month, Day, Year) August 141^, 2007

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Month

23e. Did tobacco use contribute to the cause of death?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an autopsy

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Approximate Interval Between Onset and Death

nontas

Years

R. SINDHWAN1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALDORF EM BROOKE SQUARE 11350

Sindhum

and manner stated.

31. Date filed (Month, Day, Year) State Registrar

Medical

AUG 1 4 2007

₩egistrar's Signature

		,	For State Registrar	end state of	Maryland		rtificate of			lental Hy	giene , Reg. No.	egible.	2760
*	Physici /Medi	cal	1. Decedent's Name (First, Middle Lacy Whitley	Stevens			4b. Oib. T		of Dooth	2. Date of Do Month Augus	t 09	2 0 0 7	3. Time of Death 10:30 P 💆
	Examir Funeral Director	ner	4a. Facility Name (If not institution Wicomico Nu 5. Social Security Number 468 238-22-4-68			st birthday) Yrs.	Salisk If Under 1 Yea Months Day	oury If Unde	er 24 Hrs.	8. Date of Bi (Month, D	rth ay, Year)	i COM i C	
		'n	Usual Residence of Decedent 10a. State 10b. County	,	10c. City,	Town or Lo				0/20/	1920		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the M 3a or 28a-f st be notifie	Funeral Director	MD Worc 10e. Street and Number 5903 Steffee D	ester	S:	now Hi	.11 10f. Zip Code 2186					en of What Cou	
980	permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Heatla and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 ▼ Mar 3 □ Widowed 4 □ Divorced	12. Was Dece Armed Fo ried 1 X Yes	2 □ No /e		Vas Decedent of f Yes, specify Co	Hispanic C uban, Mexic		ecify Yes or N Rican, etc.)	0- 14	Black, White	
21215-0036	rd within 72 h giene. er than "natu , the Medical	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed) College (1	-4or 5+)	(Give life. I	lent's Usual Occ kind of work dor DO NOT use reti er/Opera	e during mo red)	ost of work	ing		of Business/I	-
Maryland	ould be file Mental Hy arked othe atic event	To Be (17. Father's Name (First, Middle, Luby Stevens						Letti	e (First, Middle e Blac	kman	,	
e, Mar	1 and 2 sho Health and em 27 is m ther traum:		Phyllis E. St 20a. Method of Disposition		Lfe 20b. Pie	ace of Dispo	g Address (Stre Steffe Steffe Steffe sition (Name of	- 1		al Route Numi Hill, Date		1863 ate, 2 1963 ate, 2	
Baltimore,	mit. Pages bartment of bortant: If it injury or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5	Specify)	State ce	_{emetery, crei} enbacl	natory or other p ville C Name and Add	em.	8/12	/2007	Green	nbackvi	11e, VA
ä	permi Depar Impor any ir	6	23a. Part1. Enter the disease, o shock, or heart failure. Lis	complications that complications	aused the death.		.08 Will er the mode of d		-			1811	Approximate Interval Between
9	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a	(or as a conseque	ence of):	UNIA	,					Onset and Death
	te be executed /sician and e burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	or as a conseque								
P.O. Box 68	The law requires that the death certificate te has been signed by the attending physoage 2 should be detached for use as the	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live b	come pf pregnar birth 2 Fetal nant at time of de own	death 3[Ectopic pregnal				23	d. Date of deli Month	very Day Year
rds, P.	w requires that i been signed by should be deta	ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia								tobacco use contribute to the cause of deat		
Il Records,	Physician: The law re this certificate has be al director, page 2 sho	Completed			-				-	per 1□ Yes	opsy formed? 2 No	24b. Were au prior to death? 1 □ Yes	topsy findings available completion of cause of
or Vital	Physician: r this certifica ral director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Mannet of Death	Hospital:		ER/Outpatier	t 3 DOA	Other: Wall	Place of Death (Check only one) Nursing Home 5 Residence 6 Other (Specify)				
Division	or Attending fter death. Director: After in by the fune	Medical Certification:	1/☑Natural 5 ☐ Pendi	ng (Monigation not be 28e. Place	of injury Year) of injury - At horing, etc. (Specify,	Injury me, farm, sti	M 1	Yes 2	□No	28f. Location City or To			ral Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled i	dical C	29a. Certifier (Check only one) Certifyi Check only 2 Medica	ng Physician: To the I Examiner: On the b and man	e best of my know asis of examinati ner stated.	vledge, deat ion and/or in	n occurred at the vestigation, in m	time, date y opinion, d	and place, leath occur	and due to the rred at the time	e cause(s) a e, date and p	and manner as place, and due	stated. to the cause(s)
	To th within To the compl	Me	29b. Signature and title of certification of the second sec	er have,	7	MD 23a) (Type	D-	OO 6		5	29d. Date	signed (Mont)	n, Day, Year)

BAIDH

STEVENS

LACY

State Registrar

31. Date filed (Month, Day, Year) AUG 1 3 2007

Maesha Thimmarayappa, MD 614 Eastern Shore Dr., Salis., MD 21804

Date filed (Month, Day, Year) 32. Begistrar's Signature

			1 - For State of Maryland / Depa	rtment of Health and Me tificate of Death	ntal Hygien	(1111) / / (511)
			Decedent's Name (First, Middle, Last)		. Date of Death	3. Time of Death
	Physici	an	Dotter land Cuith		Month Da	
	/Medic	*	Betty Jane Smith 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		County of Death
	Examin	er	10834 Downsville Pike Apt. 24	Hagerstown		Washington
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)			
т	Funeral Director		220-16-2813 1 M 2 F 80 Yrs.		Date of Birth (Month, Day, Year,	,1926 Maryland
			Usual Residence of Decedent		August ZZ	, 1920 Mai y rand
	land ow		10a. State 10b. County 10c. City, Town or Loc	cation		10d. Inside City Limits
	Mary First	to	Maryland Washington Hagerstown)		1 ☐ Yes 2 ☑ No
	the 288	rec	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
	with Market	ō	10834 Downsville Pike Apt. 24	21740	11	SA
	eath	Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin? (Speci	ify Yes or No-	14. Race - American Indian,
40	ter dea	Fun	Armed Forces?	f Yes, specify Cuban, Mexican, Puerto Ri	can, etc.)	Black, White, etc.
38	Irs al	by	3 XWidowed 4 □ Divorced If Yes, Give Year or Dates:	Yes 2 No Specify:		Specify: White
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show disal Evaniner must be natified at	ted	15. Decedent's Education 16a. Deced	lent's Usual Occupation	16b. I	Kind of Business/Industry
3	within 7 ene. than "n re Medi	Completed	(Specify only highest grade completed) (Give life. L Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of working DO NOT use retired)	<i>'</i>	
21	filed withi Hygiene. other than ent, Ir.e M	E	11 0 Bloc	ker	Rib	bon Manufacturer
D	othe ent.	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name (
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event. Ite M. dical Exacilitier must be notified at	To B	Ralph G. Thompson	Anna	Ε. Ε	isenhart
37	should and Men is marke		19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	g Address (Street and Number or Rural	Route Number, City	or Town, State, Zip Code)
	and 2 ealth a m 27 is		Judy A. Taylor (Daughter) 219 W	. Main St. Waynes	boro. PA	17268
ē,	s 1 and 2 f Health frem 27 i		20a. Method of Disposition 20b. Place of Dispo			Location - City or Town, State
9	2°= =		1 ★ Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Green lawr	· · · · · · · · · · · · · · · · · · ·	OO7 Wil	liamsport, Maryland
altimore,	permit. Page Department of Important: If any injury or once.	H	101001110111			
Ba	permit. Departr Importa any inju		Dutter than 10s	sborne Funeral Home	P.A. 425	S. Conococheague S
			Enter the disease or complications that caused the death. Do not out	Iliamsport, Maryla	respiratory arrest.	Approximate
k.			shock, or heart failure. List only one cause on each line.		, ,	Interval Between Onset and Death
	Physician		resulting in death)	CES		Unknown.
	/Medical Examiner		Due to (or as consequence of):			
6		_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	sit sit	Examiner	franky, leading to immediate Cause. Enter Underlying Cause. (Disease or injury			
	and tran	кап	that initiated events resulting in death) Last Due to (or as a consequence of):			
50,	icate be executed physician and s the burial-transit		bus to (or as a consequence or).			
68760,	ate k	edical	d			
9)	n certific anding p use as	Me	IF FEMALE:			
Вох	attend for us	an/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of delivery Month Day Year
. E	e des	Physician/M	1 Tyes 2 No 4 Pregnant at time of death 5	Other (specify)		
P.0	res that the de signed by the a l be detached f	Ph.	9 Unknown		220 Did tehago	use contribute to the cause of death?
Ś	gnec be d	by	Part II. Other significant conditions contributing to death but not resulting in the un ATRIAL EIBRICLA			
ord	w require been signal	ed	AIRIGE FISHICE	71070	Yes	2 No 3 Probably 4 Unknown
၁၁၉	e lawin has be ge 2 sh	Completed	EMPHYSTMA.		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
ď	The tree has bage	ШО			performed?	death?
ital	an: rtifica tor, p	O)	25. Was case referred to medical	26. Place of Death	(Check only one)	
of Vital Records,	ysician: The is certificate hidirector, page	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	t 3 DOA Other: 4 Nursing Hom	e 5 X Residence	6 ☐ Other (Specify)
0	g Ph er th eral		27. Manner of Death 1. Natural 5 Pending (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	3d. Describe how inj	ury occurred
Division	ath. r: Aft e fun	atlo	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	M 1 ☐ Yes 2 ☐ No		
VIS.	Atte r deg ecto by th	ific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	3f. Location (Street a	and Number or Rural Route Number,
á	al or s afte Il Dir	Certification:	4 Homelos Building, etc. (Specify)		ony or rount, on	
	spita hours nera / fille		29a. Certifier Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, ar	nd due to the cause	(s) and manner as stated.
	To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be delached for use as	edical	(Check only 2 Medical Examiner: On the basis of examination and/or in one) and manner stated.	vestigation, in my opinion, death occurred	o at the time, date a	no piace, and due to the cause(s)
	To th withir To th xomp	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	AC		Kemph M.D.	5005818	/ AU	GUST 15 2007
,	11		30. Name and a ress of person who completed cause of death (Item 23a) (Type,	Print)	1 1 1 1	GUST 15 2007 MD: 7 #306 217 40
			KOBUATH PEPRAH 320	4 E. ANTIFTAM	STREET	F #306 21740
	Sta	ite	31. Date filed (Month, Day, Year) 32. Pagistrar's Signature	Print) 4 E. ANTIGTAM		
	Regist		AUG 1 8 2007 Acres A 19			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 04:30 AM Physician Princess Ashley Tolson June 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington County Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, Year)

June 24,2007 Maryland If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2X F N/A 1 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 28a-f show ns 23a or 28a-f shov must be notified at 1 ☐ Yes 🍇 ☐ No Capitol Heights Director Prince George's MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with Hygiene. 20742 U.S.A. 6944 Walkermill Rd. Apt D1 or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) nit. Pages 1 and 2 should be filed within 72 hours after d artment of Health and Mental Hylgene. ortant: If item 27 is marked other than "natural", or item injury or other traumatic event, the Medical Examiner. 1X Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 XNo 3altimore, Maryland 21215-0036 à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lisa Tolson Antonio Melara 2 18b Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Peggy Prangley-grandmother Capitol Heights, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 6-26-2007 permit. Page Department o Important: If any Injury or Smithsburg, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N 21. Signature of Funeral Service Licenses Hagerstown, Maryland Approximate Interval Between Onset and Death implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day in the past 12 menths? 1 ☐ Yes 2 X No 5 Other (specify) 4☐Pregnant at time of death ed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to þ 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should I Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Certification: To this 27. Manner of eath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 28a Date of Injury After (Month, Day Injury 1 Natural 2 Accident 5 Pending investigation hours after death.

uneral Director: Af
ely filled in by the fur 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide within 24 hours after To the Funeral Dire completely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier D64550

State Registrar 31. Date filed (Morith, Day,

DHMH 17 Rev 1/2001

Unc

gistrar's Signature

MEDICAL CAMPUS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

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32.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 7

			1 - State Registrar		ificate of D			g. No.	2/608	
	Physici	an	Decedent's Name (First, Middle, Last) WENDY BENTON THOMPSON				2. Date of Death Month JUG. 9	2007 Year	3. Time of Death 11:55 PM	
	/Medio Examir		4a. Facility Name (If not institution, give street and number) 1922 ANCHORAGE DRIVE	4	4b. City, Town, or I			4c. County of Dea	th	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ▼ F 50		If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, DEC. 20,	9. Bir (1956 MA	thplace (State or Foreign ountry) RYLAND	
	ie Maryland Ba-f show tified at	ector	Usual Residence of Decedent 10a. State	CHEST					10d. Inside City Limits 1 □Yes 2XXIo	
	ath with the 23a or 29	Funeral Director	10e. Street and Number 1922 ANCHORAGE DRIVE	Ţ.		619		g. Citizen of What C		
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Examiner must be notified at ODGE.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		as Decedent of His /es, specify Cubar] Yes 2 X No	spanic Origin? (Speci n, Mexican, Puerto Ri Specify:	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whi		
215-0036	ithin 72 h ne. nan "natu e Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kir life. DC		uring most of working	' S	6b. Kind of Business	ARYLAND	
and 21	I be filed w ntal Hygie ed other ti event, th	a B	12	ADMINI	STRATIVE	18. Mother's Name (R'S OFFICE	
Maryland	nd 2 should alth and Me 27 is mark ir traumatic	To	19a. Informant's Name/Relationship (Type. Print) ROBERT THOMPSON/ SON				Route Number,	City or Town, State, MD 21619	Zip Code)	
Baltimore,	Pages 1 a ment of Hea ant: If item ury or othe		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CHE		itory or other place	Da Park 8-16-		0c. Location - City or		
Balt	permit. Depart Import any inj		21. Signature of Furerar Service Licensee	FEL 408	Name and Address LOWS, HEL S. LIBE	of Facility FENBEIN & RTY ST., (NEWNAM CENTEVII	FUNERAL B	OME, P.A. 617	
	Physician /Medical Examiner		23a. Part1. Enter the disea x, or complication in that caused the death shock, or heart failure. List only one cur se on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequentially list conditions,	n. Do not enter	the mode of dying		respiratory arres		Approximate Interval Between Onset and Death	
68760,	tificate be executed g physician and as the burial-transit	ical Examiner	Aedical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen						
P.O. Box 6	requires that the death certificate be executed een signed by the attending physician and rould be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome pf pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	Ideath 3 □E	ctopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year	
	requires that been signed to should be deta	by	Part II. Other significant conditions contributing to death but not resul	Iting in the unde	erlying cause giver	n in Part I.			o the cause of death?	
ai Records,	The lanate has b	Completed					24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of	
·Vital	Physician; r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient	3 DOA Other	26. Place of Death () ice 6 ∐Other (Spe		
Division or	Jing After fune	Certification: T	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	28b. Time of Injury	28c. Injury Work? M 1 \(\text{T} \) Y	at 28 es 2 □ No	d. Describe how	v injury occurred		
Divi	To the Hospital or Attend Whin 24 hours after death To the Funeral Director: completely filled in by the		4 ☐ Homicide determined 2256. Flace of Injury Arrior building, etc. (Specify,	r) wledge, death o	occurred at the time	e, date and place, an	City or Town,	ise(s) and manner a	s stated	
	the Hos in 24 h he Fur pletely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	ion and/or inves	stigation, in my op	inion, death occurred	d at the time, dat	te and place, and du	e to the cause(s)	
	5	Ž	29b. Signature and title of certifier	1	29c. License	number	290	d. Date signed (Mon	th, Day, Year)	
•	(US)		30. Name and address it is son who completed cause of death (item MARY DE SHIELDS M.D. 509 IDLEY			7232 N, MARYLAN	ND 2160		2007	
H	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 4 2007 32. Polistrar's Signati	ture		u, rakilar	W 2100	/1		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 3, 2007 Month AUGUST Physician 11:50PM Louise Thompson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Saint Joseph Medical Towson Center If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6 Say 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min 1 ☐ M 2 🗡 F 220-28-3736 73 Director Maryland June 8,1934 Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2X No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be r 16902 Alcott Road Funeral 21740 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify Specify: Completed by 3 XWidowed 4 ☐ Divorced White 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 0 <u>Dietary Aide</u> Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill f Health and Mental H tem 27 Is marked oth other traumatic even Be Daniel Thompson Sr. Nora Lillian Hizer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Cousins (Daughter) 16902 Alcott Road Hagerstown, Maryland 21740 item 27 other to Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 Department of I Important: If Ite any injury or of 1 XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery August 17,2007 Hagerstown, Maryland 21. Signatural Service 22. Name and Address of Facility
Osborne Funeral Home P.A. 425 S. Conococheague St. Worll <u>Williamsport, Maryland 21795</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final disease o condition resulting in death) **Physician** CORONARY ARTERY DISEASE /Medical Due to (or as a consequence of): Examiner MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner the death certificate be executed <u>HYPOTENSION</u> burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical the as 1 IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death P.0. ed by the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 No page 2 has certificate 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 잍 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation or Attending 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 29a. Certifier 1🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D46356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21204 TOWSON. MARYLAND 31. Date filed (Month, Day, Year) OSLER DRIVE M. D. 7601 32. Registrar's Signature State AUG 1 6 2007

DHMH 17 Rev 1/2001

Registrar

			For	State of Maryland / De	partment of	Health and N	Mental Hygie	ene		
		•	1 - State Registrar	of Death	Reg	g. No. () ()	17 0761	13		
п			1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Y	3. Time of Death	V
	Physicia /Medic	_	Lugene U	Vallace			8	11 0	- 177061	М
Ĭ.	Examin		4a. Facility Name (If not institution, give stre	et and number)		n, or Location of Death		4c. County of		
				ice at the Lake		disbury			omico	
	Funeral		5. Social Security Number 6. Sek	7. Age (In yrs. last birthda	Months Day		8. Date of Birth (Month, Day, 1) Jan. 25,	(ear)13	Bouth Carolina Country)	gn
b	Director		Usual Residence of Decedent	04			Jan. 20,	1010	South Carollina	1
	land Dw		10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limit	ts
	Mary -f sh	to	Maryland Wicomico	Salisbury	7				1 X Yes 2 □ N	lo l
	r 28a	Directo	10e. Street and Number		10f. Zip Cod	e	10	g. Citizen of Wh	at Country?	
	h with		Germania	Circle	21	1801		USA		
	deat	Funeral			Was Decedent of the State	of Hispanic Origin? (Sp Cuban, Mexican, Puerto	pecify Yes or No-		American Indian, White, etc.	
õ	or its		1 Never Married 2 Married	1 XYes 2 No /1 967	1 ☐ Yes 2 🔼 i			Specify:		
2-0036	be filed within 72 hours after death with the Maryland tall Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by		Year of Dates: 8/1972					Black	
<u>ئ</u>	"nat	Completed	15. Decedent's Educati (Specify only highest grade co	ompleted) i (G	cedent's Usual Oc ive kind of work do e. DO NOT use rei	ne during most of worl	king	6b. Kind of Busi	ness/Industry	
7	within ene. than than	티	Elementary/Secondary (0-12)	College (1-4or 5+)	orer			Lumbe	r Company	
0	filed Hygi other ent, t		17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle, M.			_
Maryland 2		To Be	Seymour Wallace			Mary 3	Jamison			
a Z	should tand Menia s marked umarked		19a. Informant's Name/Relationship (Type.	Print) 19b. M	ailing Address (Str	eet and Number or Ru	ral Route Number,	City or Town, St	ate, Zip Code)	
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Bernice Wallace/sister	r 515	Old Trail	l Road, Bee	ch Island,	S.C. 29	842	
S.	ges 1 and to the lifter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem	cometery i	sposition (Name of crematory or other	place)	Date 2	0c. Location - C	ity or Town, State	
Baltimore,	Pages ment of I ant: If its ury or o		4 □ Donation 5 □ Other (Specify)	Salisbury	Cremato				ry, Maryland	
ä	permit. Pag Department Important: I any Injury o		21. Sign Jure of Funeral Service Licensee	0-11	22. Name and Ad	ldress of Facility 121	3 Jersey	Road -	Salisbury, MD	
П	20 E # 9	VI VI	+ aveca (Jolley !		MEMORIAL			21801	
			23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one	tions that caused the death. Do not	enter the mode of	dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death	
	Physician	Ů.	Immediate Cause (Final disease or condition resulting in death)	CARCINOMA	OF	LUN	as			
	/Medical Examiner			Due to (or as a consequence of):						
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):						
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
oʻ	be executed sician and burial-transit		resulting in death) Last	Due to (or as a consequence of):						
8/60	ate be executed thysician and the burial-transit	dical	d							
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Box	death certific e attending p id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		3 □Ectopic pregna			23d. Date Mont	•	
	0 0 0	sic	1 □ Yes 2 No 9 □ Unknown	4 □ Pregnant at time of death 9 □ Unknown	5 ☐ Other (specify	//				
ď	The law requires that the ute has been signed by thoage 2 should be detache		Part II. Other significant conditions contri	buting to death but not resulting in th	e underlying cause	given in Part I.	23e. Did tob	acco use contrib	oute to the cause of death?	
Vital Records,	uires tha signed I	d by					1 X e	s 2 □ No 3	□ Probably 4 □Unknov	wn
Ö	w require been signature	ete					24a. Was an	24h W	ere autopsy findings availat	hle
Re	he la e has ige 2	Completed					autopsy perform	/ pri ięgi? de	or to completion of cause o	of
g			25. Was case referred to medical			26 Place of Des	1 Yes 2 ath (Check only one		ŬYes 2 No	
	hysician: The law his certificate has t I director, page 2 s	To Be	examiner?	spital: 1 Inpatient 2 ER/Outpa	itient 3 DOA	Other:	lome 5 ☐ Reside	-	(Specify)	
Division or	g Physer this		27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Tim		Injury at Work?	28d. Describe ho		· · · · · · · · · · · · · · · · · · ·	
0	Attending Figure 19 death. Sctor. After by the funeral streets of th	atio	Natural 5 □ Pending 2 □ Accident investigation	(Moran, Day rear)		1 ☐ Yes 2 ☐ No				
N N	or Atternate or dead	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm building, etc. (Specify)	, street, factory, off	ice	28f. Location (Str City or Town		or Rural Route Number,	
	spital o									
	Hosp 24 hou Fune tely fi	edical	29a. Certifier (Check only one) Certifying Physic Medical Examine	cian: To the best of my knowledge, der: On the basis of examination and/or and manner stated.	eath occurred at the or investigation, in	ne time, date and place my opinion, death occi	e, and due to the ca urred at the time, da	iuse(s) and man ite and place, ar	ner as stated. nd due to the cause(s)	
	To the Hospital or Attending Physician: Within 24 hours a ler death. To the Funeral Director After this certific completely filled in by the funeral director,	Med	29b. Signature and title of certifler)	29c. Lic	cense number	29	d. Date signed	(Month, Day, Year)	
	⊢ s ⊢ ŏ					0058410		8-11	-07	
	Inc	15	30. Name and an ress of person who com	pleted cause of death (Item 23a) (Tv	pc, Print)	- V (1		<i>V</i>		
	\		GHULAM WAR IS CC	ASTAL HOSPIC	R P.0 (3041737	SALISI	BURY	-0)	
		ate	31. Date filed (Month, Day, Year) 4 201	32. Pigistrar's Signature	har. V .			-		
	Regist	rar	1 - 500	A CREEKS SS	AD STREET					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 08 **Physician** 7: 43 PM 2001 /Medical 45. City, Town, or Location of Death Eacility Name (If not institution, give street and number) 4c. County of Death Examiner Willomico 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day,)
June 21, Social Security Number 6 Sex 9. Birthplace (State or Foreign **Funeral** Hours Min. Months Days 1 □ M 2 X F 1933 Salisbury, MD 74 Director 214-28-8451 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.

Int. If Item 27 is marked other than "natural", or Items 23a or 28a-f show any or other traumatic event, th. Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Director Maryland Wicomico Eden 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 32619 Sea Tick Road 21822 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2**X** No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1oth Family owned business <u>Painting contractor</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be O'Henry Wilson Dolsie Wilkins ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Greensbury Whaley/husband 32619 Sea Tick Road - Eden, Maryland 21822 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Aug. 11, 2007 Salisbury, Maryland 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD 21. Signature of Funeral Service Ligensee JOLLEY MEMORIAL CHAPEL, P. A. 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only brie cause on each ne. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HUPRATRNS10N MALIGNANT /Medical Due to (or as a consequence of): Examiner CRREBROYASCULAR Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed burial-trar and Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the as nse s IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 X es 2 No 3 Probably 4 Unknown Completed 24a. Was an . Were autopsy findings available prior to completion of cause of page 2 autopsy performed? death? 1 ☐ Yes certificate 2 No 1☐ Yes 2 No Physician; director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA Medical Certification: To 1 Inpatient 2 ER/Outpatient this funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After or Attending (Month, Day Year) Injury Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ours after death.
neral Director: A
filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one)

State Registrar 29b. Signature and title of certifier

CHUMAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

COASTAL

32. Segistrar's Signature

WARIS

MOSPILA

29c. License number

02058410

29d. Date signed (Month, Day, Year)

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80 BOP# 1733, SALIS BURY UND 21802

			1 - For State Registrar	State of Marylan	nd / Depa	artment of He rtificate of D	ealth and M Death	1ental Hygier	
	Physic /Medi	cal	1. Decedent's Name (First, Middle, Last Martha Rebecca	Wheatley				August	Oay Year 3. Time of Death 0 400 M
	Examii Funeral	ner	4a. Facility Name (If not institution, give SALISBURY REHAB 5. Social Security Number 6. Se	& NURSING C		4b. City, Town, or I SALISE If Under 1 Year	BURY, MD. If Under 24 Hrs.		4c. County of Death WICOMICO
ŀ,	Director			□M 2K)F 91	Yrs.	Months Days	Hours Min.	(Month, Day, Yes 05/22/191	
)	death with the Maryland ims 23s or 28s-f show	Director	MD Wicomico		alisbu			100	10d. Inside City Limits 1 X Yes 2 □ No
	th with	al Di	1514 Riverside D	rive			1801	rog.	Citizen of What Country? USA
030	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "neturel", or Itams 23a or 28a-1 ehowevent, the Madical Extended in the houlitied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Novidowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cuban 1 ☐ Yes 2 X No	panic Origin? (Sp., Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
9500-6121	within 72 h ene. than "netu he Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4or 5+)	(Give	dent's Usual Occupat kind of work done du DO NOT use retired)		ing	Kind of Business/Industry
and z	d be filed v ental Hygie ked other t c event, th	To Be Co	9 17. Father's Name (First, Middle, Last) Walten Horner	none	Home	maker		e (First, Middle, Maid Iorseman	OWN HOME en Sumame)
, mary	ges 1 and 2 should be it of Health and Mental if Item 27 is marked or or other traumatic ev	1	19a. Informant's Name/Relationship (Ty William Wheatley/	,			nd Number or Rura		y or Town, State, Zip Code)
pallimore	permit. Pages 1 ar Depertment of Hea Importent: If Item; eny Injury or other once.		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	20b. P Removal from State	lace of Dispo emetery, cren	sition (Name of natory or other place) k Cemetery		Date 20c.	Location - City or Town, State
Dall	Depertit. Imports eny Inj.		21. Signature of Funeral Sylice tigen	unalmoo29.	22 H 5 1	Name and Address inman Fune 1673 Somer	of Facility eral Home	Princes	s Anne, MD 21853
	Physician /Medical Examiner		28a Part1. Enter the disease, or complishock, or heart failure. List onty or immediate Cause (Final disease or condition resulting in death)	ications that odused the deather cause on feach line.	n. Do not ent	er the mode of dying,	such as cardiac o	or respiratory arrest,	Approximate Interval Between Onset and Death
,007	cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due s a consequence. Due to (or as a consequence)					
.O. BOX 00	the Prospiral of Attanding Priystoten: The law requires that the death certificate be executed thin 24 hours after death. The Funeral Director: After this certificete has been signed by the attending physicien and holesely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1	death 3	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year
- ירים ביים	equires that en signed b puld be deta	5	Part II. Other significant conditions con	tributing to death but not resu	ulting in the ur	derlying cause given	in Part I.		o use contribute to the cause of death? 2
יו שפרי	: The faw r	Completed						24a. Was an autopsy performed?	
	sician certifi rector	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Ospital:		Other		(Check only one)	
	or Attending Prysicien: The law fequires the affect death. Director: After this certificate has been signed in by the funeral director, page 2 should be de	atlon: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury a Work?	4 Whursing Hor	ne 5 Residence 28d. Describe how in	6 □Other (Specify) ury occurred
	To the hospital of Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	")			City or Town, Sta	
	vithin 24 hor within 24 hor To the Fune completely fi	Medical	one)	sician: To the best of my knowner: On the basis of examinat and manner stated.	wiedge, death ion and/or inv	estigation, in my opin	ion, death occurre	ed at the time, date a	nd place, and due to the cause(s)
1	CO T With		29b. Signature and title of certifier	Otan		29c. License n	9 7	9 8	ate signed (Month, Day, Year)
4	EB		30. Name and address of person who combined WILLIAM ROBINS, M	·		,	Y, MD.	21804	
	Sta Registr		31. Date filed (Month, Day, Year) ALIG 1 5 2	32. Registrar's Signat	ture	d			

		•	1 - For State of Maryland / Department of Health a Certificate of Death		iene eg. No. 2007	27613
	Physici /Medic		Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number) Atlantic General Hospital 4b. City, Town, or Location Berlin		4c. County of Deat Worcester	٢
	Funeral Director		5. Social Security Number 211-09-1479 6. Sex 1 Months Days Hours 7. Age (In yrs. last birthday) If Under 1 Year Months Days Hours 87 Yrs. If Under 1 Year Hours	8. Date of Birth Min. 3/1/1920	0 ^{Year)} Penr	hplace (State or Foreign untry) ISYIVania
	e Maryland ta-f ehow	ctor	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 1 Yes 2 □ No
	ath with th 23a or 28	ral Dire	10e. Street and Number 1801 Boardwalk #410 10f. Zip Code 21842		0g. Citizen of What Co USA	
036	within 72 hours after death with the Maryland ene. han "natural", or Iteme 23a or 28a-f ehow 're Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexical If Yes, Specify Cuban, Mexical If Yes, Give Year or Dates:		14. Race - Ame Black, White Specify: Wh	e, etc.
Marvland 21215-0036	within 72 ho ene. then "netur	mpleted	15. Decedent's Education (Specify only highest grade completed) ElementarySecondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) Retail Manager	st of working	16b. Kind of Business/	Industry
rland 2	s 1 end 2 should be filed within the Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the M	To Be Co	17. Father's Name (First, Middle, Last) Paul Guiser 18. Moth	ner's Name (First, Middle, Mia Graf	Maiden Sumame)	
Na Za	end 2 sho ealth and h m 27 is me		19a. Informant's Name/Relationship (Type, Print) Janice Olsen 19b. Mailing Address (Street and Numb 1302 Winchester St	.,Fredricksb	ourg, VA 2	2401
Baltimore.	80=5		To Bonation of Control (opposity)	B/11/2007 F	rankford,	DE
Ba	permit. Per Depertment importent: eny injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facil 108 William Str 23a, Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as	reet, Berlin,	, Maryland	10me 21811 Approximate
514	Physician /Medical Examiner	Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	sere		Interval Between Onset and Death OUTPRING
8/16/07 1	The law requires that the death certificate be executed ate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	cal				
δ <i>D</i> δ <i>D</i> 2	that the death certific ed by the ettending p detached for use as i	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1		23d. Date of del Month	livery Day Year
3/1/2.	requires that been signed b	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part		bacco use contribute to	the cause of death?
6 8 1479	: The law recate has be	Completed		24a. Was a autops perfor 1 Yes 2	sy prior to	utopsy findings available completion of cause of
9-11 9-7	ysicien: T s certifical director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Cher 4 No C	ce of Death (Check only on	~	icify)
Paulu A 211-0 Division of	ath. r: Afte	Certification: T		□No	ow injury occurred	ural Route Number
o Oiv	ital or A	Certif	4 Homicide determined building, etc. (Specify)	City or Town		
	To the Hospital or Atte within 24 hours after de To the Funerel Direct completely filled in by ti	ledical	29a. Certifier (Check only one) Check only one)	eath occurred at the time, d	date and place, and due	e to the cause(s)
•	T with	Σ		0826 86n MD	29d. Date signed (Mont	1
_	BAZ		30. Name and address of person who completed cause of death (Item 23a) (Type Print) LAZAK - A ENIO LA 1733 Health way Pr B	sin mo	21811	
	Sta Regist					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ANGELA VITA ALAGNA 2:15 P M 26, 2007 August 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death N/A HARFORD GARDENS NURSING CENTER Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth Day, May 15, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days 1 ☐ M 2 🔀 F 218-14-1636 82 Maryland Usual Residence of Decedent 10c. City, Town or Location 10h. County 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Baltimore County Nottingham 10e. Street and Number 10f. Zîp Code 10g. Citizen of What Country? 20 Knightsbridge Court 21236 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beauty Care Hair Stylist 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Lawcence Mancini Marie Tanzella Anna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawcence Panicho (Son) 20 Knightsbridge Court, Nottingham, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐Removal from State Green Mount Cemetery 8/29/2007 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Nice 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Hone, Inc. 6500 York Road, Baltimore, Maryland Martin D. Lawson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final en disease or condition resulting in death) which Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy Dav 5 Other (specify) Part II. Other significant conditions contriguting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy

Physician /Medical Examiner

executed

certificate be

Box 68760

P.O.

Division or Vital Records,

death,

filled in by the

To the Hospital or Attenct within 24 hours after death To the Funeral Director:

Physician

/Medical

Examiner

Funeral

Director

show

r 28a-f show notified at

7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be i

72 hours after

1 and 2 should br Health and Me

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra

altimore, Maryland 21215-0036

Director

Funeral

þ

Completed

Be

2

burial-tran attending physician the use as for signed by the a page 2 certificate director After this funeral

Examine Physician/Medical þ Completed Be ို Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown 25. Was case referred to medical examiner? 1 🔲 Yes 27. Manne Death 28a. Date of Injury (Month, Day Year) 5 ☐ Pending investigation 1 Latural 2 Accident Could not be determined 3 Suicide

4 THomicide

(Check only

29b. Signature and title of certifier

performe

26. Place of Peath (Check only one)

Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

2	ER/Outpatient	3□ DOA	Other:	4 Nursing H	ome	5 ☐ Residence	6 □Other (Spec
ar)	28b. Time of Injury	28c.	Injury at Work?		28d.	Describe how inj	ury occurred

1 Yes 2 No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

8 KO. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2007

1 | Inpatient

Gracito Patricio, MD, 703 S. Clinton Street, Baltimore, Maryland 21224 31. Date filed (Month, Day, 32. Registrar's Signature

State Registrar

Medical

		1 - For State Registrar				tificate of	Death	Re	g. No.	1 1.	1010
Physici /Medio		1. Decedent's Name (First, Middle Do		derso	20			2. Date of Death Month	28 2	Vaar	Time of Death
Examir		4a. Facility Name (If not institution	give street and number		-	77 4	TMOLE			4c. County of Death Balton ore	
Funeral Director		5. Social Security Number 212-09-7364	1014 0015	ige <i>(In yrs. Ia</i> si 95	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, June 25,			(State or Fore
yland how		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Lo	cation				10d. I	nside City Lim
he Ma 8e-1 e	ector	-	imore		Bal	timore Co	ounty				I∏Yes 2∭
3e or	ā	10e. Street and Number 7410 Alvah Ave.	Ant. F			10f. Zip Code	21222	10	g. Citizen of Wi	hat Country?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time X7 Is marked other then "netural", or items 23e or 28e-f ehow any injury or other treumatic event, it is Miralical Evertil at missible notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Marr XX Widowed 4 Divorced	12. Was Deceden Armed Forces] No			Hispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race	- American Ir , White, etc. White	·
"netui	Completed by	15. Decedent (Specify only highes	's Education t grade completed)	1	6a. Deced	lent's Usual Occup kind of work done	pation during most of working d)	ng 1	6b. Kind of Bus	iness/industr	у
d withir giene. ir then	dmo	7 yrs.	College (1-4or	5+)		lesperso:			Hutzlei	r Compa	any
is a should be filed within 72 hours att this and Mantal Hygieland. To form the filed within "netural", or treumatic event, It a Maulical Every	To Be C	17. Father's Name (First, Middle,	Last)			•	18. Mother's Name		laiden Sumame	<u>.</u>	
should nd Mer marke imatic	2	John Henry Mohr 19a. Informant's Name/Relations	nip (Type, Print)		19b. Mailin	n Address (Street	and Number or Rura	therine	- ' '	State Zin Cod	(a)
Dermit. Pages 1 and 2. Department of Health ar mportent: If item 27 le nny injury or other tree.		M. John Myers (120a. Method of Disposition			741		Ave. Apt.	F Baltin		aryland	2122
it. Pages intment of intent: If it injury or o		XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service	pecify)		dens (Cem. 8-31		Baltimoı		
permi Depar Impo any ir		2 de la companya de l	222		l Li	assahn Fi	uneral Homir Rd. Bal	e timore	Md. 212	236	
Physician		232: Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that cause only one cause on each	od the death. I	Do not ente					App	proximate rval Between set and Death
/Medical Examiner		resulting in death)	Due to (or a	s a consequen		Trac.	+ Infec	t			
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. — Due to (or a	s a consequen			ייייייייייייייייייייייייייייייייייייייי				
tificate be executed g physician and as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or a	s a consequen	ce of):						
The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2	ath 3	Ectopic pregnancy Other (specify)	у		23d. Date Mont	,	Year
w requires that been signed should be del	by	Part II. Other significant conditio	ns contributing to death	but nat resultin	ig in the ur	derlying cause giv	ren in Part I.	23e. Did toba	acco use contrib	oute to the ca	
eicien: The law requ s certificate has been lirector, page 2 shoul	Completed								pri ed? de No 1 E	ere autopsy for to complet ath?	indings availation of cause o
yelcien: is certific director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ient 2□ER/	/Outpatient	3□ DOA Oth	26. Place of Death	(Check only one, ne 5 Residen		(Specify)	
ding Ph I. After th funeral	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date of Inj (Month, D		b. Time of Injury	28c. Injur Wor		28d. Describe how			
el or Attendi s after death l Director: A	Certification;	3 Suicide 6 Could n 4 Homicide determi	ned 286. Place of in	ijury - At home tc. <i>(Specify)</i>	, farm, stre	et, factory, office	2	8f. Location (Stre City or Town,	et and Number State)	or Rural Rou	ite Number,
To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical (29a. Certifier 1 Certifying (Check only one)	Physician: To the besi examiner: On the basis of and manner s	or examination	dge, death and/or inv	occurred at the tir estigation, in my o	me, date and place, a pinion, death occurre	and due to the cau ad at the time, dat	ise(s) and mani e and place, an	ner as stated.	cause(s)
To the within To the comp	Me	29b. Signature and title of certifier	MD MD			29c. Licens	06 1907	290	d. Date signed		Year)
2		30. Name and address of person v	who completed cause of	death (Item 23	A .	Print)		Mo	8 28 1	0 /	
ہے ا	te	31. Date filed (Month, Day, Year)	32. Redist	rar's Signature	ANG	nue, s	altimore	, MID	41441		
Registra		AUG 2	9 2007	Organ &	4 1	harts)					

DHMH 17 Rev 1/2001

ORIGINAL

07-06611		
David Arnold Byrd	.lr	

Please Ty

pe o	nt in Black Indelible Ink.	Ensure All Co	s Are Legil
tate of	Maryland / Department of He	ealth and Mental	Hygiene

		Registrar	Cert	ilicate oi	Death			Reg. No.			
Physicia edical Exami	an/	1. Decedent's Name (First, Middle,La	ost) OLD BYRD, JR.				2. Date of Death Month Day Year August 26, 2007			3. Time of Death 0404 hrs	
		4a. Facility Name (if not institution, gi Johns Hopkins Bayview	ive street and number)		b. City, Town, o	or Location of Dea City	th	4c. Co	ounty of Death		
		5. Social Security Number 6. 5	Sex 7. Age (In yrs. las	st hirthday)	If Under 1 Ye	ar I If Under 24H	rs. 8. Date of B	irth(MM/DD/	YYYY) 9. Bir	thplace (State or	
Funeral Director		222 22 2554	X M 2 F 30	Yrs.	Months Da		_	/197	7 Foreig	MARYLAND	
		Usual Residence of Decedent	L Inc							Co. 1	
any		10a. State 10b. County	10c. City,	Town or Locati	on					10d. Inside City Limits	
* ,	_	MD HARF	ORD E	DGEWO	OD					1 X Yes 2 No	
nylar a-fs	ę	10e. Street and Number			10f. Zip Code		100 340	10g. Citizen	of What Cour	ntry?	
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. tent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once.	Director		IA DRIVE, #E		21	041	90 1		USA		
vith tl		11. Marital Status	12. Was Decedent Ever in U.S	6. 13. Wa	s Decedent of H	lispanic Origin? (Specify Yes or N	lo- 14.	, Race - Ameri	ican Indian, Black,	
ath v	uneral	1 Never Married 2 XMarrie	Armed Forces?	If Y	es, specify Cuba	an, Mexican, Puer	to Rican, etc.)		White, etc.		
ter de	ഥ		1 Yes 2 X No	1	Yes 2 X N	lo specify:	,	· Sp	ecify: B	LACK	
irs af	by	15. Decedent's Education (Specify	or Dates:	16a. Deceden	t's Usual Occup	ation (Give kind o		16b. Kind	of Business/I	Industry	
2 hot "nat	jec	Elementary/Secondary (0-12)	College (1-4 or 5+)	during m	ost of working lif	fe. DO NOT use re	etired)			. # 74 Lin 45 Hat pt #	
36 hin 7 e. than	Completed	12TH		LOAN	OFFIC	ER		MO	RTGAG!	E COMPANY	
5-0036 iled within 7 llygiene.	,on	17. Father's Name (First, Middle, Las	st)			18.Mother's Nar	ne (First, Middle				
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Liygiene, and it frem 27 is marked other than "natural", or other traumatic event, the Medical Examine:	O)	DAVID ARNOL				DARIC	E CLAU	JDE			
2121 ould be fil Mental I marked	.o B	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing	Address (Stre	eet and Number o	r Rural Route N	mber, City	or Town, State	e, Zip Code)	
MD id 2 shoulth and m 27 is aumatic		CATALINA BYRD		3317	KERRY	ROAD,	GWYNN	OAK,	MD 21	1207	
and and tealth tem		20a. Method of Disposition			ition (Name of c	emetery,	Date	20c. Loc	cation - City or	Town, State	
Ore ges 1 t of t		1 Burial 2 X Cremation 3	Removal nom state	rematory or oth	ner place) REMATO	Dv 8	3/30/07	CA	TONSV	ILLE, MD	
ti. Pa tmen tmen rtant		4 Donation 5 Other Specia	ly.			(XI			_		
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic.	21. Sign of Funeral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOM 4600 LIBERTY HEIGHTS AVE, BALTI										
		2 d. Part I. Enter the disease, or con	nolications that caused the death							Approximate Interval	
Physician // // // // // // // // // // // // //		favore. List only one cause on	each line.		10.7		•			Between Onset and Death	
xaminer		I rediate Cause (Final disease or condition resulting in death)	a. Stab Wound of Abdome Due to (or as a consequence of				-				
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	Ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):			. 1				
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executed an and al - transit		events resulting in death) Last	d	·							
ial	Physician/Medical	UNPENDED	AMENDED								
8760, tificate be exe ng physician as the burial	Me	IF FEMALE:	23c. If yes, outcome of pregr	nancy					Date of deliver		
a is a to ∞	an/	23b. Was decedent pregnant in the past 12 months?	1 Live birth	- 11.	etal death 3	Ectopic preg	inancy	M	onth	Day Year	
Box 6 e death cer the attendi ed for use	Sici	1 Yes 2 No 9 Unknow	Wn 9 Unknown	^{ath} 5 Ot	ther (Specify)						
he de hede	Ϋ́	Part II. Other significant conditions	a OUKHOWII	eulting in the I	inderlying cause	e given in Part I	23e. Did	tobacco use	e contribute to	the cause of death?	
cords, P.O. Box 6 law requires that the death cer has been signed by the attendi 2 should be detached for use	by	Part II. Other significant condition	s contributing to death out not re	solung in the t	anconying odda	givon in raix ii				bably 4 Unknown	
S, F							– 24a. Wa	ıs an I	24h Were a	utopsy findings available	
ord w req	Completed						aut	opsy formed?	prior to death?	completion of cause of	
ec he la ate ha	mo						1 Yes		1 ✓ Y	es 2 No	
rtific tor, p		25. Was case referred to medical			26.Pla	ce of Death (Che	ck only one)				
Vital Recollysician: The la	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 ✔	ER/Outpatient	3 DOA	Other Nur	sing Home 5	Residenc	e 6 Othe	er:	
Division of Vital Records, rate or Attending Physician: The law required in Directors. After this certificate has been sited in by the funeral director, page 2 should be	-	27. Manner of Death	28a. Date of Injury	28b. Time of	Injury 28c. In	ijury at Work?	28d. Describ Subject st	e how injury	occurred		
ath. A	tio	1 Natural 5 Pending		0212 hrs	1	Yes 2 V No	Subject st	abbeu			
riSi r Att	fica	2 Accident Investigation 1 Accident 6 Could not be a could not be	28e Place of Injury - At ho	ome, farm, stre	et, factory, office	e building, etc.			Number or R	ural Route Number, City	
Div	Certification:	3 Suicide 6 Could no determine 4 ✓ Homicide		y Apt.			or Town 1931 Edgev	, State) vater Drive	e, Edgewater	, MD	
Division of Vital B To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,		29a. Certifier 1 Certifying Phys	ician: To the best of my knowledg	ge, death occu	rred at the time,	date and place, a	ind due to the ca	use(s) and r	manner as sta	ted.	
the I	Medical	one) 2 Medical Examin	ner:On the basis of examination are and manner stated.	nd/or investiga	tion, in my opini	on, death occurre	d at the time, da	te and place	, and due to the	he cause(s)	
Son With	Me	29b. Signature and title of certifier	GARA MIGINIEN STATEGO.		29c. Lice	nse number		29d. Da	ite signed (Mo	onth, Day, Year)	
		Dama M	Incorti, M.D.		0.0	C.M.E.		Augus	st 26, 2007	7	
4		30. Name and address of person wh		23a)							
11 '		Donna M. Vincenti, MD	Assistant Medical Exam		1 Penn Stree	et, Baltimore,	MD 21201				
, ,	tate	31. Date filed (Month, Day, Year)	32 Registrar's Signatu		1. 1						
	تننت	AUG 2 9 2	007 delicero de	6100	34						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Marvin 200 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner 4b. City, 4c. County of Death Bultmore HUSDITAL The Johns Hookins If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday)
Yrs. 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min **™** 2□ F 720-80-1082 Director Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 □ No Funeral Director TIMORE 10e Street and Number 10g. Citizen of What Country? Ceni 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No <u>^</u> Specify: 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Name (First, Middle, Last) 18. Mother's Name (First, Middle, Be ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) Mother 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) a. Method of Disposition Burial 2 Cremation 3 R 3 ☐Removal from State 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death uch as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** intracerebral henorthas /Medical Due to (or as a consequence of): Examiner of tensus Sequentially list conditions, Due to (or as a consequence of). Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9□Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed? Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2010 1 Inpatient 2 ER/Outpatient 3 DOA 은 After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation I Director: / 2 Accident 1 Yes 2 No 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours after within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month

mD

N. Wolfe

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 200

anning

Year)

AUG 2

August 27, 2007

xiltimore, Marward 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death o i Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** Year avable SOMO Sin /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Tenesis Lon more 8. Date of Birth (Month, Day, Year) cial Security Number if Under 24 Hrs. Age (In yrs. last birthday) 19. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖼 Months Hours Min 214-14-8573 **Director** and Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 res 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 4, 2/2/2 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 Z NO Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Be Completed by Specify Specify: Black 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) rouider 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sun Floy ဥ harles 19a. Informant's Name/Relations p (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clitton 501 Edward Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 8-31-2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Advanced ement /Medical Due to (or as a consequence of) **Examiner** 4 nentension Sequentially list conditions, if any, leaving to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a colle quence of): Examine To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by erubitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate | 2 No 1□ Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 1 Yes Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Man of Death 28a. Date of injury (Month, Day Year) 28b. Time of : After t 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the i 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0064788 MD

Registrar
DHMH 17 Rev 1/2001

State

ROYAL AUE

BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1600

			1 For State Registrar	State of Marylan		nent of Heal cate of Dea			ne _{No.} 2007	27619
	Physic	ian	1. Decedent's Name (First, Middle, Last		enner			2. Date of Death	Day Year	3. Time of Death
	/Medi Examii	cal	4a. Facility Name (If not institution, give			City, Town, or Loca	ation of Death	/	22, 2007 4c. County of Death	4:15 PM
<i>y</i>	Funeral Director	lei	Northwest 5. Social Security Number 215-92-9609 10	medical C	enter last birthday) If U	Back Inder 1 Year If U	chmi	Date of Birth	ar) 9. Birthpl	ace (State or Foreign try)
	/land ow at		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Location	1		1		Od. Inside Øity Limits
	e Mary 3a-f sh tified a	Director	md. N	'A	Bal	timo	e			1 Yes 2 No
	ath with the 23a or 28	ral Dire	10e. Street and Number 705 mTi	HOLLY S	<i>'f</i> .	f. Zip Code 212	-29		Citizen of What Coun	try?
5-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notifited at	d by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Decedent of Hispan, Specify Cuban, Mees 2 No Specify	ic Origin? (Speci exican, Puerto Ri ecify:	fy Yes or No- can, etc.)	14. Race - America Black, White, 6 Specify: B	
1212-	be filed within 72 hortal Hygiene. do other than "natuevent, the Medical	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)	(Give kind o	Usual Occupation of work done during OT use retired)	most of working	16b	Kind of Business/Ind Has pit	- · .
and	be filed tal Hyg d othe event,	Be	17. Father's Name (First, Middle, Last)			18.	Mother's Name (I	First, Middle, Maid	den Surname)	
<u> </u>	ges 1 and 2 should to the Health and Men if item 27 is marke or other traumatic.	은	19a. Informant's Name/Relationship (Ty	enner	19b Mailing Add	tress (Street and N	enevi	Route Number Ci	ty or Town, State, Zip	Cadal
, Ma	and 2 sealth ar		Bertha Cole	-sister		nt. Ho	0445	T. Ba	eto, md,	21229
ore			20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ F	temoval from State	lace of Disposition emetery, crematory	(Name of or other place)	Dat 8-30		. Location - City or Tox	0
Daitimo	- 투명류 -		4 □ Donation S □ Other (Specify) 21. Signature of Funeral Service Licens	1/1/	22. Nan	ne leng	12			ind.
<u>ă</u>	Depa Impo any Ir once.		Jany // Man	1	Gar		archi	ineral		to. nd, 2122
			23a. Part1. Enter the disease, or complete shock, or eart failure. List only of immedia & Cause (Final	cations that caused the death	. Do not enter the	mode of dying, suc	ch as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease condition resulting in death)	Due to (or as a consequ		E DEFI	achcy	الا ما ا د	-arric	
	Examiner	L.	Sequentially list conditions, if any, leading to immediate	HYP		SION				
	uted	Examiner	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	rence or);					
Ď,	ificate be executed g physician and is the burial-transit	I Exa	resulting in death) Last	Due to (or as a consequ	ence of):					
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O. DOX	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death, within 24 hours after death, for the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ ₩o 9 □ Unknown	3c. If yes, outcome pf pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 Ector	oic pregnancy r (specify)			23d. Date of deliver Month I	y Day Year
olds, r.	equires that in the second of the second of the details of the details.	by	Part II. Other significant conditions con	tributing to death but not resul	Iting in the underly	ng cause given in F	Part I.		o use contribute to the	
שה ומי	n: The law r ficate has be rr, page 2 sh	Completed	OF Was and of the day of the					24a. Was an autopsy performed 1∐ Yes 2 ☐	prior to com death?	sy findings available pletion of cause of 2□ No
<u> </u>	nystcia nis certi directo	ro Be	25. Was case referred to medical examiner?	lospital: 1 □ Inpatient 2 □ E	ER/Outpatient 3	Othor	Place of Death (C		6 □Other (Specify,	
	nding Ph th. r: After th e funeral	ation: T	27. Mann f Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes	280	d. Describe how in		
	To the Hospital or Attending Physician: The i within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At hon building, etc. (Specify)				City or Town, St		,
	the Hosp in 24 hou the Fune	edical	one) 2 Medical Examil	ician: To the best of my knowner: On the basis of examinati and manner stated.	vledge, death occu ion and/or investiga	ation, in my opinion	, death occurred	d due to the cause at the time, date	e(s) and manner as sta and place, and due to	ited. the cause(s)
	with Con	M	29b. Signature and title of certifier	M-D-		29c. License numl	ol 3	29d. [Date signed (Month E	(ay, Year)
2	T		30. Name and address of person who co	827 Lin	JDEN	WE	BALT	MORE	MD 2	1201
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 9 200	32. Registrar's Signatu	does!					

DHMH 17 Rev 1/2001

			1 = For State Registrar	State of Ma	arylan		artment c rtificate (Mental Hy	/giene Reg. No. 🤈 🏻	177	27621
Į	Physici /Medi		1. Decedent's Name (First, Middle MYRA EVA AN	e, Last) IDERSON BLANE	KENSH	116				2. Date of D Month Augus	eath £ 26, 20)))))	3. Time of Death 9:05PM
	Examir	ner	4a. Facility Name (If not institution 8127 Glen Gar	-			4b. City, Tow Parl	vn, or Loca kvill		th	4c. Count		County
	Funeral Director		5. Social Security Number 225-46-2641	6. Sex 7. Ag	72	last birthday) Yrs.	If Under 1 Y		Inder 24 Hrs ours Min.	(Month, D	rth ay, Year) .4, 1934	9. Birth Cou	place (State or Foreign ntry) iisiana
	aryland show	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo							10d. Inside City Limits
	ith the M or 28a-f	Director	10e. Street and Number	nore County		Par	tville 10f. Zip Cod	de			10g. Citizen of		1 ☐ Yes 2 No
	r death w ems 23a er must l	Funeral	8127 Glen Gary	12 Was Decedent	Ever in U.	S. 13.		of Hispan		Specify Yes or Note Rican, etc.)	o- 14. Ra		can Indian,
036	ours after ral", or its Examine	þ	1 ☐ Never Married 2 ☐ Marri 3 █ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:	No	- 1	Tes, specify t		ecify:	to Rican, etc.)	Specit	ck, White, y: White	etc. ite
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t's Education of grade completed) College (1-4or 5	i+)	(Give life. L	dent's Usual Oo kind of work do DO NOT use re	one during etired)		rking	Baltin	ore (•
Maryland 2	2 should be filed v n and Mental Hygie is marked other t raumatic event, th	To Be Co	17. Father's Name (First, Middle, Thomas		decso				Mother's Nar		Ponder		ac busits
Mary	and 2 should I ealth and Men n 27 is marke ier traumatic		19a. Informant's Name/Relationsh Eve L. Greco	nip (Type. Print) (Daughter))						oer, City or Town Lle, Mac		
Jore,	Pages 1 and 2 nent of Health int: If Item 27 iny or other tra		20a. Method of Disposition 1 💢 Burial 2 □ Cremation	3 ☐Removal from State	20b. P	lace of Dispo emetery, cren	sition (Name o natory or other	f place)		Date	20c. Location	City or To	own, State
Baltimore,	permit. Pa Departmen Important any Injury		4 Donation 5 Dother (St. 21. Signatu 3 Function Serve	cepsed Awren	DUIL)/ Timon al Home,		Macyland
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Moto Due to (or as a	a consequ	n. Do not ente	er the mode of	dying, suc	ch as cardia	arcumore c or respiratory a	e, Maryl	and >	Approximate Interval Between Onset and Death 3 YLALS.
Box 68760,	leath certificate be executed attending physician and I for use as the burial-transit	an/Medical Examiner	resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	c	pf pregna	onsequence of):					23d. Da	ery	
o.	at the deal by the att	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnant at 9□Unknown			Ectopic pregna Other (specify				Mo	onth	Day Year
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o uo	Attending Physician: r death. ector: After this certific by the funeral director,	tion: T	27. Manner of Death 1 Datural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	у	28b. Time of Injury	28c. l	njury at Work? I □ Yes			how injury occur		77
DIVISION	2 4 7 -	Certification:	3 Suicide 6 Could no determine		ry - At hor :. (Specify	me, farm, stre	et, factory, offi	се		28f. Location (. City or To	Street and Numb wn, State)	er or Rura	l Route Number,
	To the Hospital or Att within 24 hours after de To the Funeral Direct completely filled in by t	edical (29a. Certifier 1 ✓ ertifying (Check only one) 2 ☐ Medical E	Physician: To the best of xaminer: On the basis of and manner sta	examinati	wledge, death ion and/or inv	occurred at the estigation, in n	e time, dat ny opinion	te and place , death occu	, and due to the irred at the time,	cause(s) and ma date and place,	anner as s and due to	tated. the cause(s)
	To the vithir comp	Me	29b. Signature and title of certifier) / -			ļ	ense numb			29d. Date signe		
	0/	1	30. Name and address of person w	V o completed cause of de			rint)	148			8/2	7/0	27
	Star		Aldolpho Lope: 31. Date filed (Month, Day, Year)		Ruxto r's Signat	on Land	Suit	e 109	, Tow	son, MD	21204		
	Registra	il I	AUG 2 9	2007 Lane	1	K Bo	PACE !						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12:10PM **Physician** Jugust 26 ,2007 Darger harles /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 4 pme OWSON norca 31129 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (th yrs. last birthdav) 8. Date of Birth
[Month, Day, Year) **Funeral** Days Months Hours 1**⊠**M 2□ F Aary/and Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene. Sym 27 Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County la or 28a-f show t be notified at Baltimore 1 XYes 2 No Director Mary land 10g. Citizen of What Country? 10e. Street and Number 212/2 Inston Avenue ns 23a must b Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) traumatic event, the Medical Examiner 1 Yes 2 No If Yes, Give Year or Dates: 1. Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ashier oraw's Grade 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be reodore Vaonu 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a_Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health at
Important: If Item 27 Is
any Injury or other trau Avenue atricia 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 3 Removal from State 1 Burial 2 □ Cremation asant Rest 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funeral Service Licensee -Floris Fune al Home Road 4210 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) CHRONIC SEVERE **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner be executed burial-trar Due to (or as a consequence of): physician Physician/Medical the use as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the a 9 Unknown 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page 2 autopsy perform death? 1 ☐ Yes 2∏No 2 No Division or Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) end manner stated. 29d. Date signed (Month, Day, Year) 29c. License number D-0012849 29d. Date signed (Month, Day, 29b. Signature and title of

State Registrar 31. Date filed (Month, Day, Year)
AUG 2 9 200



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

1600 ESLER Dr. TOWSON MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** AUGUST 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deat Examiner NURSING Home ISAL TIMOR 5

If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month) Day 5. Social Security Number 6. Sex **Funeral** Days 1□M 2**X**F Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. 11. Marital Status Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian. Black, White, etc. 1 | Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) /Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be 2 Informant's Name/Relationship (Type. Print) Laughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of 20a. Method of Disposition Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licenses WINDOTT 23a. P. rtf . Enter the a snor k, or heart a Imme Y te Cause (Final disease or condition resulting in death) Enter the Mease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart is lure. List only one cause on each line. Approximate Interval Between Onset and Death SEP515 **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease o. Inju. y that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MEUITUS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) 20 No Hospital: Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAPHAEL

Registrar

31. Date filed (Month, Day, Year)

AUG 2

DHMH 17 Rev 1/2001

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32. Registrar's Signature

00

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

		For State Registrar		State	of Marylan	-	artment of F tificate of	lealth and N Death		jiene leg. No 2	07	27624	
Physicia	an	1. Decedent's Nam	ne (First, Middle	e, Last)					2. Date of Dea Month		Year	3. Time of Death	
/Medic	al	SHETLA 4a. Facility Name (If mad implify this m	A.		BRADFO		- I continue of Dooth	08	27 2	.007	6 A M	
Examin	er			A EXPRESS	,		DUNDA	r Location of Death LK	ı		nty of Death TIMOR	E	
Funeral Director		5. Social Security N 217-40-9		6. Sex 1 □ M 2 F	7. Age (In yrs. 64	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	, Year)	9. Birth	place (State or Foreign ntry)	
	2.	Usual Residence o	f Decedent			. Town as I a		1.	10 20	1772			
faryla show	ō	10a. State	10b. County	(ODE	10c. Cit	y, Town or Lo						10d. Inside City Limits 1	
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h with	Ö	7801 PEN	A.IIISIIT.A	EXPRESSV	JAY		21222			US		,	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Mari 3 ☐ Widowed	ried_2 Marri	12. Was De	ecedent Ever in U. Forces? s 24 No Give		Nas Decedent of H f Yes, specify Cub I ☐ Yes 2 No	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	В	14. Race - American Indian, Black, White, etc. Specify: BLACK		
hin 72 h	Completed	(Spec		st grade complete	d) (1-4or 5+)	(Give	OO NOT use retire	during most of work	king	16b. Kind of		dustry	
ed wit	Сод						NURSE				ALTH		
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should nd Me mark matic	ို	19a. Informant's N				19b, Mailin	a Address (Street	and Number or Ru			vn. State. Zii	o Code)	
alth ar 27 is 27 is er trau		MARIAN F						E UNIT 3					
of Hei of Hei fitem r othe		20a. Method of Dis		3 □Removal fro		Place of Dispo	sition (Name of natory or other place	ce)	Date	20c. Location	n - City or To	own, State	
nit. Pag artment ortant: I Injury o			5 ☐ Other (S _i	pecify)		STANI		08-3] ss of Facility JA		UNDALK ORTON		S F.H. INC	
Dep any once		Lar	nes a	No	Im		1701 LAUF	NES STRE	ET, BALT	O., MD			
Physician		23 x Part1. Enter thook, or head immediate Cause disease or condition	(Final	complimation that only one cause or	t caused the death each line.		er the mode of dyir	ng, such as cardiac	or respiratory and			Approximate Interval Between Onset and Death	
Medical Examiner bhysician and the burial-transit	Examiner	Due to (or as a consequence of): b. Due to (or as a consequence of): b. Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury hat initiated events resulting in death) Last Due to (or as a consequence of):											
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eath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	months?	1 ☐Live	outcome pf pregna e birth 2 Feta gnant at time of d known	aldeath 3□	Ectopic pregnancy	/		23d. Date of delivery Month Day Year			
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Physician; The law i this certificate has be ral director, page 2 sh	Completed	Hyr		ridemi	۹				24a. Was a autop perfor 1∐ Yes	sy	b. Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of	
siciar certif	Be	25. Was case referexaminer?		Hospital:	☐Inpatient 2☐	EB/Outpotion	Oth	er:	/				
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To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one)	1					me, date and place opinion, death occu					
To the To the Complex	Me	29b. Signature and	AF	-	MO		29c. Licens	e number 4/3 9	9	29d. Date sig	ned (Month,	0 the cause(s) Day, Year) 7 10 2120	
8		30. Name and add	ress of person v	who completed ca	use of death (Item	23a) (Type,	the Point	Bhd.	St 72	4 B.	oll 1	1821204	
Stat	e	31. Date filed (Mon		3 2.	Registrar's Signa	ature	al ^p .		-				
Registra		AU	G 2 9 2	007 Alex	Jan Si	PATON							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #30, per DVR, g870, 8/29/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of D **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Care Center Baltimore Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 1 □ M 2√□ F Director 451-34-0404 90 2/28/1917 Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d Inside City Limits 28a-f show Item 27 Is marked other than "natural", or items 23a or 28a-f sh other traumatic event, the Medi-al Examiner must be notifiled 1 ☐ Yes 2☐No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8800 Walter Blvd 21234 apt 1112 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: þ White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Schweitzer Katherine Kramer ည Henry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son Fredericksburg, VA 22407 Jay R. Bell Waverly Drive 3517 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of I Department of Important: If It any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 8/31/2007 Baltimore, MD 22. Name and Address of Facility 5305 Harford Rd. Inc. Baltimore, MD21214 Leonard J. Ruck, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) P.O. | 1 Tyes 2 TNo 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4.☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an ate has autopsy performed certificate 2 No 2 1NO 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Matural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ō Hospital 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Manth, Day, Year) Type, Print) 30. Name and address of person who completed cause of death (Item 23a) 31. Date filed (Month, Day, Year) 32. Pogistrar's Signature State Registrar

Doris

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#5 perFH G871 9/6/07 WS
State of Maryland 7 Department of Health and Mental Hygiene U T

52 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 24 Month Year 930 **Physician** AM 3217 AUGUST 13R16H 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE DORAS 11 8. Date of Birth (Month, Day, Year) NOVEMBER 9, 1937 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 69 Director OHIO Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State itams 23a or 28a-f ahow ner must be notified at 1 Yes 2 No Director MD. BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code USA 31792 DORI AVENUE Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 2 0 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ō Specify: Specify: other traumatic event, It e Medical Exert 3 ₩idowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if itam 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) HOSPITAL NURSES ASSISTANT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be RIGSBY JOSEPH GLADYS 2 SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4145 DORIS AVE WALTER DEAN BRIGHT (SON) BALTO. MD 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition BAYVIEW CREMATORY 81 1 Burial 2 Cremation 3 Removal from State = 5 permit. Page Department of Important: if any injury or once. 8/28/07 BALTO 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility GONCE FUNERAL SERVICE P.A. 21. Signature of Funeral Service Licensee Domerousk 4001 BALTO. HWY 21772 RITCHIE 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE LARDI **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical the IF FEMALE: esn esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 🗷 No ρ 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by HANNEL 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 20 No 1 Tyes Division of Vital To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\sum \) Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2 No Pis 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined within 24 hours after dea To the Funeral Diracto completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number D000251 2007 ZU30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4710 15H812 ENNINGTON ICICHARD 32. Registrar's Signature 31. Date filed (Month, Day, Year) parke State AUG 2 9 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 11:47 pm **Physician** ZO DONALD CARTER /Medical 4b. City, Town, or Locetion of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner uture Care-Charles Village 2327NCharlest ast birthday) If Under 1 Year BAITIMORE If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yea 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 214-44-1705 Usual Residence of Decedent Director Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits th and Mentel Hygiene. 7 is marked other than "natural", or flams 23a or 28a-1 show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No 1 timore Be Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2/205)ay A0+#/(
12. Was Decedent Ever in U,S.
Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2/2 No 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ZUM permit. Peges 1 and 2 should be file.
Department of Health and Mentel Hyg.
Important: if Item 27 is merked other any Injury or other traument 18. Mother's Name (First, Middle, Maiden Surname) 's Name (First, Middle, Last) arleen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip ode) 19a. Informant's Name/Relationship (Type, Print) 105 Barb MD 21208 ic. Location - City or Town, State Joane 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 1 ☐ Burial 2 Cremation 3 Removal from State atom 8/24/07 Baltimore 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ldo MD 2/223 Stricker Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or hear failure. List only one seen each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Be Completed by Physician/Medical Examiner efter death.

I Director: After this certificate hes been signed by the ettending physician end in by the funeral director, page 2 should be deteched for use es the bunel-transit Attending Physician: The law requires thet the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 DNo 1 ☐ Yes 2 ☐ No 1 🗆 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Li Natural 5 Pending 1 Yes 2 No investigetion 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital o within 24 hours of To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier -0 175 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 1600 W MOUNT DARSHAN SALUI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State ford. Registrar

	06382 omas Campb		State	or Print in Blace of Maryland / I	Departmer	nt of Heal	th and			ble.		7 2762
	Physicia		1- For State Registrar 1. Decedent's Name (First, Middle,La	ast)	Certificat	e of Deat	n		Reg. 2. Date of Death	No.	3	. Time of Death
Me	edical Exami		Thomas Roy	Campbel	I Jr.					ay Year 2007		0020 hrs
1			4a. Facility Name (if not institution g Bon Secours Hospital	ive street and number)		4b. City, 1 Baltin		ocation of Death	4	4c. County o	Death A	
	Funeral Director		nn 111	Sex 7. Age (In yrs. last birthd	ay) If Und Month	er1 Year Is Days	If Under 24Hrs. Hours . Min.	8. Date of Birth	MM/DD/YYYY)	g. Birthr Foreign Coun	. 4 .
	v any:	e	Usual Residence of Decedent 10a. State 10b. County	10	oc. City, Town or							0d. Inside City Limits
	vith the Maryland s 23a or 28a-f show a	Director	10e. Street and Number	}	Balti	more 10f. Zip			, 10g	. Citizen of Wh	at Countr	1 XYes 2 No
5	th the N 23a or 2 20tified		1019 McAleer					202	E* . E.	u:		
	r death wit or items 2 must be n	Funeral	11. Marital Status 1 Never Married 2 Marrie	1 X Yes 2	ver in U.S. 1	If Yes, speci	fy Cuban, N	anic Origin? (Sp Mexican, Puerto		White		n Indian, Black,
	2 hours afte "natural";	d by	3 Widowed 4 Divorce 15. Decedent's Education (Specify	only highest grade compl		ecedent's Usual	Occupation	specify: n (Give kind of w		Specify: 6b. Kind of Bus	siness/Ind	lustry
	5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+) du	carpe		OO NOT use retir	ed)	Home	m	provement
	21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	17. Father's Name (First, Middle, Las Thomas Roy Ca	mpbell 8	r			Shirle	<u> </u>	wh		
	and 2 should beattle and MD 21 sealth and Mer tem 27 is mar transmatic ever	٢	19a. Informant's Name/Rela onship Edgrenia Lam	/ . ^	19b.	Mailing Address	(Street a	nd Number	urli Route Numb	er, City or Towr	n, State, 2 √ID	21201a
	ore of H	77.	20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State		Disposition (Naty or other place)	- I	1	20c. Location -	•	
	Baltim permit. Pag Department Important:		4 Donation 5 Other Special Signature of Funeral Service Lice	ensee	Ouros				npassion	Funer	als	enlices
			forest for Just for	MDD944	a donth. Do not	3000	E. Bo	altimon	e' Street	T Balt	D. MI	21224 Approximate Interval
	Physician //Medical //Examiner		23a. Part Uniter the disease, or confailure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	each line. Cocaine a arrest and re Due to (or as a consequence)	estraint	ced agita	ted de	lirium ass	sociated w	ith polic	è	Between Onset and Death
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a consequence of): c.								
1	uted nd ransit	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	uence of):							
٧), be exec sician a	dica	X UNPENDED	X AMENDED #23a #1,perME,g	PII,27,28 871,9/28/	a=f perl	Æ,g876	5, 2/7/08	TT			
	Box 68760, e death certificate be executhe attending physician and office use as the burial - tra	sian/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at tir	of pregnancy 2	Fetal death		Ectopic pregna	ncy	23d. Date of Month	delivery Da	y Year
	Box e death the atte ed for u	Physici	1 Yes 2 No 9 Unknow		5 [Other (Spe	ecity)					
	ords, P.O. v requires that the sbeen signed by t	by	Part II. Other significant conditions Atherosclerotic	-	-	in the underlyin	g cause giv	ren in Part I.				bly 4 Unknown
	of Vital Records, ng Physician: The law require After this certificate has been si meral director, page 2 should b	Completed							24a. Was ar autopsy perform 1 V Yes 2	/ pied? c		opsy findings available mpletion of cause of
	tal Reco cian: The law certificate has ector, page 2 s	Be C	25. Was case referred to medical examiner?					f Death (Check				
	of Vit ing Physica After this connected in	To E	1 ✓ Yes 2 No	Hospital: 1 Inpatient	-		DOA O		g Home 5 R	esidence 6	Other:	
À	on of anding Ph	ion:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Yea Fnd 8/17/2	r)	me of Injury 11:17 pm		s 2X No	unk	w injury occurr	eu	
	Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be exceuting 4 hours after death. the Fineral Director: After this certificate has been signed by the attending physician and piptelly filled in by the funeral director, page 2 should be detached for use as the burial - tra	Certification:	2 Accident Investigat 3 Suicide 6 K Could no determin	ation 28e. Place of Injure		n, street, factor			28f. Location (Stror Town, Sta	ite)		al Route Number, Ĉity altimore, MD
#	Hospital 24 hours Funeral etely filled		29a. Certifier 1 Certifying Phys	ician: To the best of my l	knowledge, death	n occurred at th			due to the cause	(s) and manner	as state	i.
	To the Hos within 24 h To the Fun	Medical		er:On the basis of exami and manner stated.	nation and/or inv		c. License			nd place, and d		
		2	29b. Signature and title of certifier	1. Kery:	Theme) 29	O.C.M	DOM		August 18,		, vay, 15a1)
_	10		30. Name and address of person who Theodore M. King, Jr., M			ner 111 P	enn Stre	et, Baltimore	e, MD 21201			
	S Regis	ate trar	31. Date filed (Month, Day, Year)	40.1	Signature	fole	,					

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DHMH 17 Rev 1/2001

Registrar

Robert T. Turner, M.D., 7600 Osler Drive, # 311, Towson, Maryland 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

AUG 2 9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 'shard Collins 25 2001 302 A M August 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) N Hopkins Hospital If Under 1 Birthplace (State or Foreign Country) 5. Social Security Number Days 1**X**M 2□F 215-75-0772 reglar March 24 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Pres 2 No Ma. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 3 2 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship-(Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mom oh 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 0 4 □ Donation 5 □ Other (Specify) memi 22. Name and Address of Facility 21. Signatur of Funeral Servic / Lice Daceto, md, 214 P. mar 23a. Part. Priter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Lause (Final disease or condition resulting in death)

a. Respiratory fullure

Due to or as a condition or as a condition or as a condition. Approximate Interval Between Onset and Death Respiratory fuil Due to or as a consulence of): 12 months Spinal muscular atrop 17 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2XNo 3 Probably 4 Unknown -ischemic encephalopath 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

injury or other traumatic event, the Medical

nd Mental Hygiene. marked other than

Health and Mental em 27 Is marked o

permit. Pages 1 an Department of Heali Important: If Item 2 any injury or other

Director

Funeral

2

Be Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

The law requires that the death certificate be executed burial-tran attending physician as the I for use detached has

or Vital Records, P.O. Box 68760,

Examiner Physician/Medical 2 Completed Be Certification: To

funeral director, page 2 certificate Physician: After this or Attending death. within 24 hours after deal To the Funeral Director n by filled Hospital

State Registrar

Medical

Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier August 25, 2007 RES-000 and a sof person who completed cause of death (Item 23a) (Type, Print) 30. Name Nelson 600 North Wolfe Street, Blabck 904, Baltimore, NO 21287 IMA 32. Registrar's Signature 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #5, perFh, G871, 9/4/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Edna H. Cavey August 26, 2007 11:41 P.M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Ridgeway Manor Nursing Home Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 XF 9, 98 Jan. 1909 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County r 28a-f show notified at 10a. State 10d. Inside City Limits 1 ☐ Yes 2X No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or is any Injury or other traumatic event, the Medical Examiner must be n 2209 Belleview Road 21228 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 █No Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Emil Haefner Minna Anna Loose 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2209 Belleview Road; Catonsville, MD 21228 Robert C. Frey, Sr. Nephew altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 D Other (Specify) Yausoleum Loudon Park Cemetery 8/29/2007 Baltimore, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Foneral S 1630 Edmondson Avenue; Catonsville, ase, or complications that caused the death.

e. List only one cause on pach ling. Approximate Interval Between Onset and Death 50 Years Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Fordisease or condition resulting in death) Physician /Medical Du o (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate the land of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9□Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 TYes 20 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has performed' 2 No 2/2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 200 No Nursing Home 5 Residence 6 Other (Specify) ည 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this s after deam.

/al Director; After the funers Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury Natural 2 Accident 5 Pending investigation 1 Tes 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) completely and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 0

3

State Registrar

DHMH 17 Rev 1/2001

cause of death_(Item 23a) (Type, Print)

32 Registrar's Signature

2 9

2007

405 tre

07-06492 Bradford Diggs

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

0	1	. k	derive 5	, 3		. ~	1	
Ć.	U	Towns .	1	C	1	5	J	L

	1- For State Registrar Certificate of De	ath Re	g. No.
Physician/	1. Decedent's Name (First, Middle,Last)	Date of Death Month	h 3. Time of Death
Medical Examine	2 20 0 0 0 1 1 2	August 21,	, 2007 2240 THS
		Itimore	N/A
Funeral			h(MM/DD/YYYY) 9. Birthplace (State or
Director	212-46-7835 1 MM 2 F 61 Yrs. MC	onths Days Hours Min. April 1	9, 1946 Foreign Country) MD
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
ow any			1 1 Yes 2 No
Maryland 28a-f show d at once.	MD N/A Balt/m 10e. Street and Number		og. Citizen of What Country?
after death with the Maryland al", or items 23a or 28a-f sho iner must be notified at once.	1701 Eutaw Place	21217	1200
death with triems 23a	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dec	edent of Hispanic Origin? (Specify Yes or No-	
r death		ecify Cuban, Mexican, Puerto Rican, etc.)	White, etc. APM Com
s after miner	3 Widowed 4 Divorced in Yes, Give Year 1 Yes	2 No specify:	Specify: American
"natu		ual Occupation (Give kind of work done working life. DO NOT use retired)	16b. Kind of Business/Industry
5-0036 ed within 72 ho tygiene. other than "na the Medical Ex	12/5	Laborer	Construction
5-0036 led within 7 Hygiene. I other than the Medica	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, M	
121 d be fill fental F arked arked	19a. Informant's Name/Relationship (Type, Print) , 19b. Mailing Addi		. Blagmond
MD 21215-00: 12 should be filed with th and Mental Hygene to 27 is marked other th tumartic event, the Mec		ress (Street and Number or Rural Route Num E. 33 RD St. Balti	
2 2 2	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date	20c. Location - City or Town, State
imore Pages 1 ment of F tant: If or other	1 Burial 2 Cremation 3 Removal from State crematory or other plants of the plants of t	1ce) 3 (memortum 8/29/07	Boilthmone MD
Baltimore, octumit. Pages I an Depar ment of He Important: If ite injury or other tr	21. Signature of Funeral Service Licensee 22. Name	and Address of Facility	Service, P.A. Battimone MDZ1206
<u> </u>	14-(5126 Belovin Road	Baltimore MD 21206
Physician Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mo- failure. List only one cause on each line.	de of dying, such as cardiac or respiratory arre	Between Onset and
xaminer	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		Death
	Sequentially list conditions, b.		
iner	if any, leading to immediate Due to (or as a consequence of):) i
ed nsit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
760, icate be executly physician and the burial - tra	AMENSE, PII, 27, 28a-f, perME, go	371, 9/4/07 TT	03d Date of delivery
876 rtificat ing ph as the		ath 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
Box 687 e death certifit the attending ct for use as t hysician/	4 Pregnant at time of death 5 Other (Specify)	
D. Bc t the dea	Part II. Other significant conditions contributing to death but not resulting in the under	ving cause given in Part I. 23e. Did to	bbacco use contribute to the cause of death?
res that the d signed by the detached be detached d by Phy	Diahetes mellitus		2 No 3 Probably 4 Unknown
ords, w requir s been s should t		24a. Was a	
Records, The law requires freate has been sig gage 2 should be		perfor	rmed? death?
tal Reccian: The certificate ector, page	25. Was case referred to medical	26.Place of Death (Check only one)	1 103 2 10
f Vital Physician or this cert ral directo	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other Nursing Home 5	Residence 6 Other: Scene
Ing Pl	27. Manner of Death 1 Natural 5 Reading 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		how injury occurred
ivisior or Attenc after death Director: I in by the	Pending Investigation Fnd 8/21/2007 10:40 pm 28e. Place of Injury - At home, farm, street, fac	1 Yes 2 X No unk	Street and Number or Rural Route Number, City
Division of Vital Records, P.O. spital or Attending Physician: The law requires that th tours after death. neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach. Certification: To Be Completed by P.	3 Suicide 6 X Could not be determined (Specify) residence	or Town, S	w P1, Apt 201 Baltimore, MD
Di Hospital 24 hours a Funeral tely filled	29a. Certifier 2 Certifying Physician: To the best of my knowledge, death occurred a	t the time, date and place, and due to the caus	se(s) and manner as stated.
Fo the within Po the comple	one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.		
ع ا ا ا	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
9	Mphua Brasne 4, 1118	O.C.M.E.	August 22, 2007
1	30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn	Street, Baltimore, MD 21201	
State	31. Date filed (Month, Day Year) 32. Registrar's Signature		
Registra			

ORIGINAL

		1	For State Registrar	State o	of Marylar		artment of H		d Mental Hyg	giene	7 27633
			negistrar Decedent's Name (First, Middle, La	ist)					2. Date of Dea	ath	3. Time of Death
ш	Physicia	an		eSANTIS					August	23, 2007	7:20A M
4	/Medic Examin		4a. Facility Name (If not institution, git				4b. City, Town, o	r Location of De		4c. County of	
	LAGITIT		Glen Meadows				Glen A	\rm		Bal	timore
	Funeral		5. Social Security Number 6.	Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 H	lin. 8. Date of Birt (Month, Da June 13	h y, Year)	9. Birthplace (State or Foreign Country)
	Director	- 1		¹□M XXF	97	Yrs.			June 13	3, 1910	Pennsylvania
	and W	-	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	Aaryli sho	ō	Maryland Baltimo	wa.	G	ilen Ar	m				1 □Yes 2√Wo
	28a-	Directo	10e. Street and Number	71 6		itell At	10f. Zip Code			10g. Citizen of Wh	
	3a or		11630 Glen Arm Ro	o a d			21057			USA	
	death ms 2	Funerai	11. Marital Status	12 Was Dec	edent Ever in U	l.S. 13.	Was Decedent of H	lispanic Origin?	(Specify Yes or No		- American Indian, White, etc.
9	after or ite		1 ☐ Never Married 2 ☐ Married	1 DYes	orces? 2 XX No ive		1 ☐ Yes 2 \(\) (No	Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify:	White
21215-0036	be filed within 72 hours after death with the Maryland that Hyglene. ad other than "natural; or items 23a or 28a-f show event, the Medical Evarifier must be notified at	d by	3XXVidowed 4 ☐ Divorced	Year or I	Dates:						
5-	"natu	Completed	15. Decedent's E (Specify only highest g)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of	working	16b. Kind of Busi	ness/industry
12	filed within Hygiene. ther than " int, the Me	ш	Elementary/Secondary (0-12)	College	(1-4or 5+)		mstress	-/		Tailor	,
d 2	filed Hygi other ent, L		17. Father's Name (First, Middle, Las	t)				18. Mother's	Name (First, Middle,		
an	should be filed nd Mental Hygi marked other imatic event, I	To Be	Guiseppi Ricci					Gui	lia Ev <mark>a</mark> nge	elista	
Maryland	s 1 and 2 should be f Health and Mental H Item 27 is marked of other traumatic evel		19a. Informant's Name/Relationship		C				Rural Route Number		
	1 and 2 Health tem 27 i	l 4.	Renato P DeSantis		Son			Court	Hunt Valle	•	
ore	0 0	- 8	20a. Method of Disposition XXBurial 2 ☐ Cremation 3	Removal from	State	cemetery, cre	osition (Name of matory or other pla		Date		City or Town, State
Ë	Pag tment tant:	1 8.	□ Donation 5 □ Other (Spec	ify)	Gar		f Faith				re, Maryland
Baltimore,	permit. Page Department. Important: if any injury o	1	21 Signature of Fund Service Local Service L	Kena	Ris	2	2. Name and Addre				eral Home Inc ryland 21212
			23a. Part1. Enter the disease, or conshock, or heart failure. List of	nplications that	caused the dea each line.	th. Do not en					Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition	Mh	oscler	tic.	cardion	ascula	n dise	usl	Oriset and Death
4	/Medical Examiner		resulting in death)	Due to	(or as a conse	quence of):					
	Examine	L	Sequentially list conditions,	b		morac de					
/	ed sit	oline	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
_	xecut and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a conse	quence of):					
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit			d.							
687	ificate g phys as the	edic									
Вох	eath certific attending pl for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant		utcome of pregr birth 2 - Fet		⊒Ectopic pregnanc	v			of delivery th Day Year
	deat	sicia	in the past 12 months? 1 Pyes 2 Pyo		nant at time of		Other (specify)	,		Mont	II Day Teal
P.0	that the de	Phys	9 Unknown					un in Don't	23a Did	tobacco use contril	bute to the cause of death?
	signed to	þ	Part II. Other significant conditions	A Contributing to	and of the	Suiting in the t	manying cause gr	veniniran.	1 🗆	1/	3 ☐ Probably 4 ☐Unknown
oro	w requir been si should	eted	0170000	- 1	1	.,				04h W	/ere autopsy findings available
of Vital Records,	elaw has b	Completed			/				24a. Was auto	psy 🖊 pr	rior to completion of cause of eath?
= E	icate r, pag										☐ Yes 2☐ No
Vita	Physician: The law this certificate has by ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:	Inpatient 2] ER/Outpatie	int 3□ DOA Ot	hor 1	Death (Check only only only only only only only only		r (Specify)
of	Phys r this aral di	. To	27. Manner of Death	28a. Date	e of Injury	28b. Time			~7	how injury occurre	
on	Attending For death, ector: After by the funeral	tion	1 Natural 5 Pending 2 Accident investigat		nth, Day Year)	Injury		nk?]Yes 2 □No			
Division	Attendi r death, ector: A by the fu	ifica	3 Suicide 6 Could not determine	be 28e. Plac	ce of Injury - At i	home, farm, s	treet, factory, office			(Street and Numbe wn, State)	or Or Rural Route Number,
	s afte	Certification;			dirig, oto. (opoo						
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying Check only one)	aminer: On the	ne best of my kr basis of examin nner stated.	nowledge, dea nation and/or i	th occurred at the to nvestigation, in my	ime, date and p opinion, death o	place, and due to the occurred at the time,	cause(s) and mar , date and place, a	nner as stated. nd due to the cause(s)
	To the vithin To the comple	Me	29b. Signature and title of certifier				29c. Licen	se number		29d. Date signed	(Month, Day, Year)
	->		> And Post	My	mo		1 03	0433		My 23	, 2007
	3		30. Name and address of person wh	o completed ca	use of death (Ite	om 23a) (Type	(MAOAF)	57	BUTIMOR	E mo	21204
		ate	31. Date filed (Month Par Year)	2007 32.	egistrar's Sign	nature	Land D	01	J 10 11 11 10 110 110	V	
	Regist	rar		2007	FELLE J	JO SO	Sales Consultation of the Sales				

			For State Registrar		State of M	1arylan		artmen rtificat					Reg. No.	007	27634	
	Physici /Medic		1. Decedent's Name William	e (First, Middle, Daiker,	-							2. Date of De Month August	Day 27	Year 2007	3. Time of Death 9115 AM	
	Examin		A = 000 A A 200 A 1 A 10 A 1 A 1 A 10 A 1							Location o			4c. (County of Death	1	
	Funeral Director		5. Social Security N 215-30-38		. Sex 7. A 1,	Age <i>Univr</i> s.	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir	th 1 /19 3	9. Birth	nplace (State or Foreign untry)	
	anyland show	5	Usual Residence of 10a. State MD	Decedent 10b. County Baltim	ore		y, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 No	
	with the M s or 28a-f be notifile	Director	10e. Street and Number 125 Rodeo Circle											Citizen of What Country?		
036	within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes 2 Never Married Bright Status					Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto F	pecify Yes or No- Rican, etc.) 14. Race - American Inc Black, White, etc. Specify:White			e, etc.	
within with the n		Completed	(Spec		grade completed)	de completed) (Give life. L			dent's Usual Occupation kind of work done during most of working DO NOT use retired) er Specialist					ndustry e Gas cric		
Maryland	should be filed ind Mental Hygin i marked other umatic event, I	To Be C		7. Father's Name (First, Middle, Last) William Carl Daiker						18. Mothe Heler	or's Name n Eli:	(First, Middle zabeth	, Maiden S Long	Maiden Sumame) ong		
	nd 2 shoulth and 27 ts m		19a Informant's N Linda Spe	ame/Relationshi ear/Daugh	p (Type, Print) Liter		4	•					Whit	Town, State, Z e Mars	sh, MD 2110	
Baltimore,	# C .		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetary, crematory or other place) Chesapeake Crematory 20c. Location - City or Town, State Beltsville, Maryland													
Balt	permit. Page Department of Important: if any injury of once.		21. Signature of Fu	ineral Service Li	censee Rult	MOL						Altern rive B			ryland 21286-	
	Physician /Medical Examiner		23a. Part1. Eniter t shock, or hea Immediate Cause disease or condition resulting in death)	rt failure. List or (Final	Due to for a	line. <u>2st IVe</u> as a consec	Heart quence of):	faile	(Ye	g, such as	cardiac oi	r respiratory a	rrest,		Approximate Interval Between Onset and Death 1 Year	
8760,7	icate be executed physicien and s the burial-transit	ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Chronic Obstructive Pulmo w Due to (or as a consequence of):										20 years 2 months			
P.O. Box 68	death certifi e attending id for use as	Physician/Medi	IF FEMALE: 23b. Was deceden in the past 12 1 \(\text{Pyes} \) 2 \(\text{9} \(\text{Unknown} \)	months? ⊒No	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)					2	3d. Date of deli Month	very Day Year			
	uires that I signed by id be deta	۵	Part II. Other signi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to									the cause of death?			
al Recor	n: The law requires that the ficate has been signed by th r. page 2 should be detache	e Completed	05 Was assessed							perfo 1 Yes	autopsy prior to completion of cause of death?					
Division of Vital Records,	Attending Physicien: r death. ector: After this certific by the funeral director.	ToB	25. Was case referexaminer? 1 Yes 2 2 27. Manner of Deat 1 Natural 2 Accident	No	28a. Date of in (Month, L	28a. Date of Injury (Month, Day Year) 28b. Time of Injury				t 3 DOA Other: 4 Nursing Ho			th (Check only one) ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			
Divis	F & F E	Certification;	3 Suicide 4 Homicide	6 ☐ Could no determin	286. Place of I				y, office		2		fl. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospitel of within 24 hours af To the Funeral D completely filled in	Medical (29a. Certifier (Check only one)	1 Certifying 2 Medical E	Physician: To the be xaminer: On the basis and manner	of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim , in my op	ne, date an pinion, dea	id place, a	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
)	within To th	Ž	, ,	inna j	Onatataj,		D+			438			Aug		, 2007	
	541		Danna	a Dorat	otaj, M	0-		Print) Union	Me	morid	L He	spital,	Bal	timore,	MD 21218	
	Sta Regist		31. Date filed (Mor	AUG'Z'S	2007 32. 1991	strar's Sign	aturg Ad	Carrie .								

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r Print in Black Indelible Ink. Ensure All Copies Are L	.egible.		
of Maryland / Department of Health and Mental Hygiene		2057	27535
Cartificate of Death		Second Co.	

		1- For State Registrar		Cen	tificate of	Death			F	teg. No.		
Physicia edical Exami	in/ ner	1. Decedent's Name (First, Midd Walter Willia	lliam Fritz Month Day Ye August 25, 2007								3. Time of Death 1818 hrs	
		4a. Facility Name (if not institute 3644 Hughes Lane	4	4b. City, Town, or Location of Death Middle River				4c. County of Death Baltimore County				
Funeral Director		5. Social Security Number 217-74-9251	6. Sex 7.	Age (In yrs. Ia	ist birthday) Yrs.	If Under 1 Ye Months Da		.Min.		8/1965	Foreig	thplace (State or in untry) MD
w any		Usual Residence of Decedent 10a. State 10b. County			Town or Location	on						10d. Inside City Limits 1 XYes 2 No
n the Maryland 3a or 28a-f show otified at once.	Director	MD Harf 10e. Street and Number 2913 Craigsto		Abin	gaon	10f. Zip Code 21009		÷		10g. Citizen of W		13
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Modrial Hygiene more 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	Funeral D	11. Marital Status 1 X Never Married 2 N	12. Was Deced Armed Ford		If Ye	Decedent of Hes, specify Cuba	an, Mexican,	Puerto F		o- 14. Race Whit	e - Ameri te, etc.	can Indian, Black, White
72 hours after "natural",	sted by	3 Widowed 4 Di 15. Decedent's Education (Spe Elementary/Secondary (0-12)			16a. Decedent	Yes 2 X N 's Usual Occup est of working life	ation (Give	kind of wo	ork done	Specify:		
Nore, MD 21215-0036 uses I and 2 should be filed within 72 tt of Health and Montal Hygiene t: If item 27 is marked other than ' other trainmatic event, the Medical	Comp	12 17. Father's Name (First, Middle			Mechan	ic				Maiden Surnam		e Rëpair
ore, MD 21215-00. se I and 2 should be filed with of Heath and Montal Hygiene If item 27 is marked other the trainmatic event, the Moc	To Be	William Frit 19a. Informant's Name/Relation Kristina Alta	ship (Type, Print)	ter			eet and Num	aber or R		eman Imber, City or Tov . Hill, N		
More, Pages I and ent of Heakint: If item		20a. Method of Disposition 1 X Burial 2 Crematic 4 Donation 5 Other S	n 3 Removal from	20b. F	Place of Disposi crematory or oth	tion (Name of c er place) Je Memo)	cemetery,	08/3	Date 80/07	20c. Location	- City or	Town, State Maryland
	(T)	21. Signature of Funeral Service Olegondro 23a. Part i. Enter the disease, c	Botes	and the death	53	05 Hart	ford R	load,	Balti	more, MI	213	
Physician /* /Medical xaminer		failure. List only one caus Immediate Cause (Final diseas or condition resulting in death)	e on each line.	ntoxicat:	ion compl				-	riest, silook, of the		Between Onset and Death
	kaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a condition of the conditi								-	
760, ficate be executed physician and the burial - transit	/Medical Ex	X UNPENDED	dAMENDED.27	,28a-f, j	perME,g87	1, 9/7/0	7 TT					
n of Vital Records, P.O. Box 68760, doing Physician: The law requires that the death certificate be executed h. After this certificate has been signed by the attending physician and enumeral director, page 2 should be detached for use as the burial - transit	siciar	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 23c. If yes, ou	utcome of pregi th nt at time of de	nancy 2 Fet			c pregna	ncy	23d. Date of Month		ry Day Year
i, P.O. B ires that the d signed by the	d by Phy	Part II. Other significant cond			esulting in the u	nderlying caus	e given in Pa	art I.				the cause of death?
Division of Vital Records, tal or Attending Physician: The law requir safer death. al Director: After this certificate has been seled in by the funeral director, page 2 should t	Completed						_	-	per	opsy formed?		utopsy findings available completion of cause of es 2 No
Vital Rec hysician: The l this certificate I	o Be C	25. Was case referred to medic examiner? 1 ✓ Yes 2 No	Illognital	patient 2	ER/Outpatient		Other		only one) g Home 5	Residence 6	✓ Othe	er: Scene
[라 호 st 으 .	-	27. Mapper of Death 28a Date of Injury 28b Time of Injury 28c, Injury at Work? 28d, Describe how injury occurred										
Division ospital or Atten hours after deatt meral Director;	Certification:	2 Accident 3 Suicide 6 X Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 3644 Blk. Hughes Lane Mi 29g. Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								Middle River,		
To the Ho within 24 To the Fi	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	aminer:On the basis of	examination a	ge, death occur ind/or investigat	ion, in my opini	ion, death or	ccurred a	t the time, da	te and place, and	due to t	he cause(s)
Brod	=	/ //	on who completed cause	of death (Item	1 23a)	1	C.M.E.			August 26		
O. COM		Mary G. Rippe MD.	Deputy Chief M	edical Exa	miner 11	Penn Stre	et, Baltim	ndre, M	D 21201			
S Regis	tate trar		2 9 2007 &	istrar's Signati	A A	Belle.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** FAW 5:55AM 0 August 25 2007 IAMES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner St. AGNES HUSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1√2 M 2□ F 69 09/10/1937 Maryland Director 219-26-8534 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County iral", or items 23a or 28a-f shov Examiner must be notified at 1 XYes 2 No Director Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. U.S.A.
14. Race - American Indian, Funeral 21216 2523 West North Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 ☐ I If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🗌 No 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: Black <u>م</u> 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other than "natu 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Bakery 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 Is marked or traumatic even Catherine Carberry မ William L. Faw Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 Is any injury or other trauonge. 4413 Groveland Avenue, Baltimore, Maryland 21215 <u>Joseph Faw / Brother</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Ceme. 08/31/2007Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of FacilityThe Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Licensee 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician LUNG CANCER EARS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** YEARS HIPERTENSION Sequentially list conditions, if any local limit declarate. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed′ 1 Yes 2 ☑ 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated.

JAMES

State Registrar

31. Date filed (Month, Day, Year) AUG 2 9 2007

useph

29b. Signature and title of certifier

osiph

manno 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

wanmoh



MD



29c. License number

D46505

29d. Date signed (Month, Day, Year)

25, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 08/27/2007 **Physician** Betty Lou Freeman 12:44P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 65 Lake Shore Drive Pasadena Anne Arundel If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F 06/24/1945 62 MD 214-44-3997 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 ☐ Yes 2 ☐ No notified Director Anne Arundel MD Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a or Examiner must be 21122 65 Lake Shore Drive U.S.A. 72 hours after death Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: þ White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore than Elementary/Secondary (0-12) College (1-4or 5+) 12 Paraprofessional City School District permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Calvert Margaret J. Firnstein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarence Freeman/Husband 65 Lake Shore Drive, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 08/28/07 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility G. J. Gonce Funeral Home, 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 7 MONTHS resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as asn 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1☐Yes 2☐No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1□ Yes 2 🗷 No Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient P 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Injury 1 Natural 5 Pending investigation al or Attendir s after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours at To the Funeral D 1 🚰 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Registrar

5

State

(Check only

29b. Signature and title of certifier

MILYARL

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

and manner stated.

JHBVML

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

URICH

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

4940 EASTELY AVE BALTIMOR Nd 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND THE MISSING PORTER C871 0/10/107 WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month NUGUST Year **Physician** EANETTE GARDNER Gorman 6:45 PM 7007 /Medical 4c. County of Death Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 402PITAL RANDAUSTOWN Baltimone NORTHUNEST If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 27, 199 Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Director mn Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural" --- any injury or other traumatic everal. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Wood lawn 1 ☐ Yes 2 ☐ No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 70515 by Funeral 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No 3 Nidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSIN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6205 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 DrCremation 3 ☐ Removal from State Bay wen Crenky 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Jervice Livensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPTICEMIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** CELLULITIS WALL ABDOMINAL Sequentially list conditions, frank, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duerto (ur es a consequence o Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? for Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) ned by the a detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed' In the name of the death.

To the Funeral Director: After this certified the Funeral Director. After this certified the funeral director. To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Phopatient 2 □ ER/Outpatient 3 □ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D54352 2007 on) AUGUST 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TODOR MITCLEA trospital 5401 OLD COURT ROAD TZ =W HIJION 21133 PLANDALLSTOWN 31. Date filed (Month, Day Near)? 7 7 32. Registrar's Signeture State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** DANA GRADY วี7 6:53 AM AUGUST 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimone er 1 Year | If Under 24 F Bon N/14 If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In vrs. last birthday) **Funeral** Months Days 1 M 2 F 212-96-5900 Usual Residence of Decedent Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the IM-10a Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 □ Yes 2 □ No **Funeral Director** Raltimone MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1519 21216 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc.

AFMCem 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2□Mo þ 3 ☐ Widowed 4 ☐ Divorced Amenican Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Walmart ales Clerk 100 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Darlene ပ္ 19a. Informant's Name/Relationship (Type. Print) . 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. MD 21223 M. Denise 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State Zion Cem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

105 C

512 6 B Plan 21. Signature of Funeral Service Icensee Funera Road MD 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Farluso Physician disease or condition resulting in death) /Medical Due to (or s a consequence of) Examiner stantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Inknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 2□ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has b rector, page 2 sl autopsy 2 10 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 □ Yes 2 □ No 1 | Inpatient 21☐ET/Outpatient 3☐ DOA After this c funeral din 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗖 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

3

State Registrar 31. Date filed (Month, Day, Year)

AUG 2

DHMH 17 Rev 1/2001

Name and address of person who completed cause of death (Item 23a) (Type, Print)

		Please Type or Print in B				_	e.	
		FOR	d / Department of Healt Certificate of Dea		ntal Hyg	iene	7 09610	
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, Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Locati			4c. County of	Death	
		SINAL HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. I	BALT) MOR		. Date of Birth	9	Birthplace (State or Foreign	
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pun		Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Location		- / - /		10d. Inside City Limits	
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fter dea r items iner m	Funeral	11. Marital Status 1 □ Never Married 2 Married 12. Was Decedent Ever in U.: Armed Forces? 1 □ Yes 2 No	If Yes, specify Cuban, Mex		can, etc.)	Black,	White, etc.	
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permit. Pages 1 and 2 should be filed within Inportants of Health and Mental Hygiene. Importants if item 27 is marked other than any injury or other traumatic event, the Monee.		20a Method of Disposition 20b. P	Place of Disposition (Name of emetery, crematory or other place)	Dat	te	20c. Location - Ci	ty or Town, State	
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/Medical Examiner		resulting in death) Due to (or as a consequence)	uence of):					
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Attending Physician: The law requires that the death certificate be executed reash. Total and the this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	_	Data to (et als a consequ	derice ory.					
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iclan: The lav certificate has ector, page 2	e Co	25. Was case referred to medical	26.5	Place of Death	1 Yes	2 54 10 1	Yes 2 No	
Physician: this certific	To Be	examiner?	Othor			ence 6 □Other	(Specify)	
Ing Ph Vitter th Uneral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year)	28b. Time of lnjury at Work?		d. Describe h	ow injury occurred	i	
vttendi death. ctor: / y the fi	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At his determined building in the Constitution of the could be suited in the country of	M 1 ☐ Yes				or Rural Route Number,	
al or A	Certification:	4 Homicide determined building, etc. (Specify	y)		City or Town	n, State)		
To the Hospital or Attendir within 24 hours after death. To the Funeral Director: After completely filled in by the full	Medical (29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my kno 2 ★ Medical Examiner: On the basis of examina and manner stated.						
To the vithin ? To the comple	Mec	29b. Signature and title of certifier	29c. License numi		2	29d. Date signed ((Month, Day, Year)	
		NILESH J. PATER MD	D006	4957		August	24,2007	
10		30. Name and address of person who completed cause of death (Item NILESH J. PATEL 2401 W	BELVEDERE A	AVE . F				
Sta Registi		31. Date filed (Month, Day, Year) 2007 32. Registrar's Signer	ature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month 0240 AM Physician Griffin August Gladys 28 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE NIA AGNES MOSPITA L If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 F Days Yrs. 218-22-6410 9-22-1925 Virginia Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, t<u>he Medical Examiner must be notified</u> at 1 Yes 2 No MD NA BALTIMORE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Athol AVENUE 21229 2 2 South Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify 1 ☐ Yes 2 ☐ No Specify: Black altimore, Maryland 21215-0036 ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. laundry laborer 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vannie Brumgode ennie ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Daugh Ley 21228 Balbinore, MD Road Hallwood 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Ballimore My Zion Cemetery 4 □ Donation 5 □ Other (Specify) Carlton C. Hongland Funeral Service P.A. 1701 Mc Celled St. Baldo. U.S. 21217 21. Signature of Funeral Service Lisensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac Arry Homico **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 687605 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 Probably 4 Unknown Completed Sacral Decubihs Vice 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA To the mosphers within 24 hours after death. To the Funeral Director. After this of the funeral director and the funeral director. Certification: To 1 ☐ Yes 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2007 DEA B19916795 MIS

'n

State Registrar 31. Date filed (Month, Day, Year)

AUG 2 9 2007

Meghan Checkley

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Flyistrar's Signature

Bulhmore

21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 11 per spouse 6889 3/25/09 dk. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 7:35 PM 24 illie E. GRISSOM 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 555 W. Townson Blvd. Gilchrist Hospice Towson, Maryland Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours 6.5 243-64-4647 17,1942 Director Louisburg, N.C Usual Residence of Decedent r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 21213 USA 3020 E. Street Federal Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Widowed 4 Divorced 1 ☐ Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Bluck à Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Mechanic Auto permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other i any injury or other traumatic event, <u>tit</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Flossie Jones Bennie Li Grissom ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 219 Cambridge Ln Newtown PA. Oveta C. Grissom/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State St. Laus Cemetery S.
22. Name and Address of Facility Dundall, 4 ☐ Donation 5 ☐ Other (Specify) Sept 1, 2007 21. Signature of Funeral Service Licensee Rinald H. GRAYCON Fureral Ser 270 Fred fretin Pap Back ma uneral Sery rie 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) of head and Physician wamma umths /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IE EEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Ves 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 s autopsy performed certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Sther (Specify) WSP(Ce Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: To the Hospital or Attending within 24 hours after death.

To the Funeral Director; After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide PErcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 58303 25 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 670/ N. Charles ST TOWN MO HARLES MO AMON 31. Date filed (Month, Day, Year) Registrar's Signature State AUG 2 9 2007 La Select Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #8, perFH, C870, 8/29/07 TT Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Edward Geis Jr 2:25 P Charles August 24 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Stella Maris Hospice Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Social Security Number 212 24 2465 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☑ M 2 ☐ F 1928 Frostburg, MD Director December Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location ns 23a or 28a-f show must be notified at 1 ☐ Yes 2√ No Maryland Baltimore Baltimore County Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8316 Annalee Avenue 21237 LISA Funeral items ? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after thealth and Mental Hygiene.

27 Is marked other than "natural", or itee the traumatic event, the Medical Examiner 1 X Yes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify Specify: þ White 3X Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore County Schools Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Edward Geis Sr Elizabeth Henley ၉ 19a. Informant's Name/Relationship (Type. Print) Steven S Geis (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 Gardenia Drive Hanover, PA. 17331 permit. Pages 1 and 2: Department of Health a Important: If Item 27 Is any injury or other trauonce. Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc August 25 2007 Baltimore, Maryland 22. Name and Address of Facility 21. Signatule of Funeral Service Licensee EF Lassahn Funeral Home PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as can be or respiral ory arrest land. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CEREBROVASCULAR ACCIDENT disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed for use as the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 4□Pregnant at time of death nis certificate has been signed by the a director, page 2 should be detached in 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 2 After this certificate 2X No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To HOSPICE 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 141 TARIO MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

2007

AUGUST 24,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Charles Edward Gordon /Medical Aug 24, 2007 4c. County of Death 4:00 a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Joseph Richey Hospice, Inc. Baltimore N/A If Under 1 Year | If Under 24 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director 218-22-8528 Mar 2, 1929 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anones. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 ☐ No Director Maryland N/A **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 South Catherine Street 21223 Funeral U.S.A 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 1961 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black 106.1 16a. Decedent's Usual Occupation Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) City of Baltimore Tow Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Harry Gordon Elise Brush 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mozell Gordon Wife 20 South Catherine Street Baltimore, Maryland 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/29/07 Owings Mills, Md. Garrison Forest Veterans Cemetery 21. Sign xur of Funeral Ser Estep Brothers Funeral Service, P. A.

1300 Futaw Place Baltimore, Md 21217

shock, or hear failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

23a. Part 1. Enter Me disease, or complications that caused me death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

The immediate Cause (Final disease or condition resulting in death) 22. Name and Address of Facility Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 25 No 9 ☐ Unknown 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Jnknown certificate has been si rector, page 2 should 24a. Was an Was a.. autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 6 Dother (Specify) 105 pice After this the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 24 hours after death. e Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier To the Hosp within 24 hor To the Fune completely f and manner stated 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Eutan St Baltimore MD Hospice So 32. Registre

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

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Charled Herein

's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 1245 PM GAMBRELL MANDY 23 2007 AUGUST /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner NORTHWEST HOS PITAL BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign 6. Sex Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 F Months Hours Min. Director 78 Aug 5, 1929 So. Carolina 247-38-5786 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d Inside City Limits 10b. County or 28a-f show Examiner must be notified at 1 ☐Yes 2 ☐ No Director **Baltimore** Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with then of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or items 23a or? 21208 U.S.A. "natural", or items 23a 7209 Brookcrest Way Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ X o Specify. Black 3 ₩idowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Rosewood Hospital Center Nurse's Aide 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eliza Richey Joshua Blackwell ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Warren Park Drive Baltimore, Maryland 21208 Lucille Goode 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ott 1 □ Surial 2 □ Cremation 3 □ Removal from State 08/28/07 Laurel, Maryland 4 Donation 5 Dother (Specify) Maryland National Park Cemetery 21. Signature of Funeral Sovice Licens 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or comshock, or heart failure. List only slications that caused the Approximate Interval Between Onset and Death leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition lamintor /Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IE FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2★□No 24a. Was an has autopsy performed? Yes 2 ZNNo this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: within 24 hours after death. To the Funeral Director; After 5 ☐ Pending investigation Injury (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 ☐ Homicide Hospital 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Registrar AUG 2 9

31. Date filed (Month, Day, Year)

Patro

WATSON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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ATRICK

32 Registrar's Signature

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HOSPITAL

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5401 OF COURT ROAD

			1 - For State Registrar	State of M	1arylar			nt of H te of L		nd Me		ene g. No.	007	2764.6
	Dhysisi		1. Decedent's Name (First, Middle, Last)							2	2. Date of Death Month	Day	Year	3. Time of Death
	Physici /Medio		HELENA	GIVENS							August	11,	2007	4:30 P M
	Examir	ner	4a. Fecility Name (If not institution, give		r)			_	Location of	Death			ounty of Death	
			Laurel Regional Ho		na (In vre	last birthday)		ure I	If Under 2	4 Hrs. g	B. Date of Birth	Pr		eorge's place (State or Foreign
	Funeral Director			M 2X) F 9	2	Yrs.	Month		Hours	Min.	9/19/19)14	Fai	rfax, VA
			Usual Residence of Decedent		_Y		1				5, 15, 1.	- 1		
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	₫₽₽ ■ व		Terry A. Austin 23a. Part1. Enter the disease, or compli										nington	DC 20011
	Physician /Medical Examiner		shock, or heart failure. List only or firmediate Cause (Final disease or condition resulting in death)	e cause on each	o Scl	erotic								Interval Between Onset and Death
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O. DOX	the death or y the attend iched for us	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant : 9 ☐ Unknown	2 🗌 Feta	aldeath 3]Ectopic] Other (pregnancy specify)				230	d. Date of deliv Month	ery Day Year
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=	sician: The law s certificete has b lirector, page 2 s										perform 1 Yes 2	No No	death?	2 □ No
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DIVISION	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificete his completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be 4 Homicide determined		etc. (Specil	fy) 					City or Town,	State)		al Route Number.
	Mospl 24 hou Funer etely fill	edicai	(Check only 2 Medical Examinations)	inian. To the besiner: On the basis and manner s	ot examina	owledge death ation and/or in	vestigation	d at the tim n, in my op	e, date and inion, death	place, an occurred	d due to the car I at the time, da	te and pla	ace, and due t	nated. to the cause(s)
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	į.		30. Nam and address of person who co	mplete Juse of	death Mer	n 23a) (Type,	Print)	ا لي		200	l aura 3	MD	2070	Ω
	1		YED A. SADIQ, MD -				ie K	pad, S	ou i te	۷۷۵,	Laurel	, I'IU	2070	0
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 9 2007	32. Regis	trar's Signa	ature	9						*	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Voor **Physician** 11:00 AM August 23, 2007 Marshall Andrew Green Sr. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Holy Cross Hospital Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Days Months Hours Min. 1 M 2 □ F 93 PA 09/27/1913 207-07-7087 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 No Director MD Prince Georges Upper Marlboro 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code United States 20774-9804 Lakepoint Court Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Ma Yes 2 □ No
If Yes, Give W W II
Year or Dates: W W II 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗷 No Specify: þ Specify: 3 ☐ Widowed 4 M Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hotel Elementary/Secondary (0-12) College (1-4or 5+) Waiter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Jackson Herbert Green ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9510 Vance Place Silver Spring, MD 20901-Terrance Green/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Aug 27 1 ☐ Burial 2 MCremation 3 ☐ Removal from State Beltsville, Maryland 2007 Chesapeake Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Rapp Funeral & Cremation Services 21. Signature of Funeral Service Licenses Style & Jolymann 933 Gist Ave. Silver Spring, Maryland 20910-Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of): Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Osteomyelitis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760. attending physician use as the ò P.0. cate has been signed by the page 2 should be detached Division or Vital Records, certificate funeral director, After this Hospital or Attendi Hours after death. Funeral Director: A ely filled in by the fu death. 24 hours a Hospital Medical

Funeral

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'natural", or

permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "naturany Injury or other traumatic event, the Medical

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/Medical

Examiner

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72 hours after

Baltimore, Maryland 21215-0036

To the I within 24 b7 29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 2

9

State Registrar

1221 Mercantile Lane, Largo, MD Carl Johnson M.D., 32. Registrar's Signature 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

1 🕱 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D045881

29d. Date signed (Month, Day, Year)

20774

August 23, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend 20b-c, perFH,0870, 8/29/07 TTCertificate of Death Reg. No. 3. Time of Death 2. Date of Death gedent's Name (First, Middle, Las Day Month Year **Physician** 21.04 PM shind AUGUST 2007 /Medical acility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE ST AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 02-22-7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1□M 2**√**F 87 220-22-2987 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 28a-f show notified at 10a, State 1 Yes 2 No more **Funeral Director** the 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number must be n death v 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 14. Race - American Indian ıral", or items 2 I Eхатіпег mu Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after remt of Health and Mental Hygiene. ant: If I then 27 is marked other than "natural", or iten ury or other traumatte event, the Medical Examiner ury or other traumatte event, the Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Blac Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) omesti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) House 1x pt. 101, burtax Nbusine Jo Anne Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal from State Important: If It any Injury or o once. 8/30/2007 4 Donation 5 ☐ Other (Specify) Mt. Zion Baltimore, MD 22. Name and Address of Facility Va. 515 Balto. Nat'l 4 Ke Vaugho, C. Greene Funeral Services 21. Signature of Funeral Service License Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANOXIC ENCEPHALOPATHY **Physician** DAMS /Medical Due to (or as a consequence of): Examiner DAYS SYSTEM FAILURE MULTIORGAN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine WEEK. PNEUMONIA The law requires that the death certificate be executed and Due to (or as a consequence of): physician Division or Vital Records, P.O. Box 68760 DEEP VENOUS THROMBOSIS CHRONIC RENAL INSUFFIENCY MONTHS Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ZUnknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 2 3 No 1 ☐ Yes 2 ☐ No certificate 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient ၉ in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: (Month, Day Year) 1. Natural Injury 5 | Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Macertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

GRIER, CLAKA

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 JAIN

> 9 200

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

CATON AUENUE 32. Registrar's Signature ENG-

M.D

BALTIMORE

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

P20347

29d. Date signed (Month, Day, Year)

172007

AUGUST

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 XYes 2 □ No

Year

200

SA

Month

death?

Day

24b. Were autopsy findings available prior to completion of cause of

2 No

Year

Black, White, etc.

DHMH 17 Rev 1/2001

State Registrar 32 Registrar's Signature

Year)

		•	For State Registrar		State of M	arylan	-			ealth and N Death	/lental Hy	giene Reg. No.	200	
	Physici	an	1. Decedent's Name (Robert Jo								2. Date of De Month	Day	Year	3. Time of Death
	/Medic Examin	-	4a. Facility Name (If n				-	4b. City	Town, or	Location of Death	08/20		County of Dea	0.20
			Future Ca						ngto				ltimor	
e- ·	Funeral Director		5. Social Security Num 216-30-229	96 11		ge (<i>In yr</i> s. 73	last birthday) Yrs.	Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 08/30/	ay, Year)	9. Bir	thplace (State or Foreign ountry) MD
	land bw tt		Usual Residence of De 10a, State 1	0b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
	a-f sh	ctor	MD 2	Anne Aru	ndel	Pasa	adena							1 ☐ Yes 2 ☐ No
	th with the 23a or 28 ist be not	Funeral Director	10e. Street and Numb					10f. Zi 21	Code 122			10g. Citiz US.	en of What Co A	ountry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.		11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4	1	12. Was Decedent Armed Forces? 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	,		Was Dece If Yes, spe 1 ☐ Yes		ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		4. Race - Ame Black, Whi Specify: W	te, etc.
21215-0036	within 72 ho ane. Ihan "natul ie Medical	Completed by	(Specify Elementary/Second	5. Decedent's Ed only highest grad lary (0-12)	ucation de completed) College (1-4or	5+)	16a. Dece (Give life. Electr	kind of wo	ork done d ise retired	during most of work	king	1	d of Business ustrial	
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aryl	should and Me s mark	<u>و</u>	19a. Informant's Nam	ne/Relationship (7	ype. Print)		19b. Mailir	ng Addres	s (Street	and Number or Ru	ral Route Numb	per, City or	Town, State,	Zip Code)
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Ball	permit Depart Import any in		21. Signature of Fine	and the	MO	1378	Ga 72	ESO W	. Kau	ss of Facility ufman Fur ngton Bly	neral Ho d., Elk	me at	t MMP,	INC 21075
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical Co	29a. Certifier 1 (Check only 2	IXCertifying Ph ☐ Medical Exam	ysiclan: To the best niner: On the basis of and manner s	of examina	owledge, deat ation and/or in	h occurred	d at the tir n, in my c	ne, date and place pinion, death occu	, and due to the irred at the time	e cause(s) , date and	and manner a place, and du	as stated. ue to the cause(s)
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•		-	30. Name and addres	ss of person who	completed cause of	death (Iter	m 23a) (Type.					- 1009 •		
	811		James Tan	nginda 1	350 Armors	, Pla	Ce Sui	t = 31	H, Ba	ltimore,	MD 212	17		
	Sta Registi		31. Date filed (Month,	Day, Year)	32. Region 32. 7	far's Sign	ature	Cost	Es					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** M Edith M Hess August 26 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Health Center Harford County
If Under 1 Year | If Under 24 Hrs. Harford 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Yrs 214 01 1125 90 Director October 2 1916 Baltimore, Maryland Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland salth and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County an "natural", or items 23a or 28a-f show Medical Examiner must be notifled at 1 ☐ Yes 2 ☐ No Director Maryland Harford Fallston 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1702 Chateau Court 21047 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 【XXINO If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: ģ White XX Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than the N Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Housekeeping-Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Maximillian Martin Louisa Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan H. Berg 1702 Chateau Court Fallston, Maryland 21047-2104 permit. Pages 1 and. Department of Health Important: If item 27 any Injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition tXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Parkwood Cemetery August 29 2007 |Baltimore,Maryland 22. Name and Address of Facility
Lassahn Funeral Home Inc. 21. Signature of Funeral Service Licens 7401 Belair Road Baltimore, Maryland 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Myocardial Infarction Immediate Cause (Final howers **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Hospital or Attending Physician: ?4 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 1npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Notified 24 hours after death.

To the Funeral Director: After the funeral by the 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certific

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

9 2007 m13.

m 0 500

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Kevin Cyrk & D 5(7)

D35012 August 27, 2007

Upper Chasapanke Drive Bol Air, Md. 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #23e, 24a, ,25,27, per 10,870, 8/29/07 TT State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 21, 2007 12:07 pM Aug. Harry Joseph Hagner, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Dundalk 1907 Eastfield Road If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F Director <u> 217-50-3411</u> March 12, 1948 Maryland Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Director Dundalk Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7 is marked other than "natural", or items 23a or traumatic event, the M-dical Examiner must be it United States 21222 1907 Eastfield Road Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: þ 3 ☐ Widowed 4 ☑ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Steelworker Manufacturing 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Shirley L. Peters Harry J. Hagner, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health ar Important: If Item 27 is any injury or other trau Dundalk, Maryland 21222 1907 Eastfield Road (Mother) Mrs. Shirley Hagner 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Pk 8/24/2007 Dorsey, Maryland 21. Signatut Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not ever the mode of dying, such as cardiac or respiratory arrest, shock, or hear railure. List only one cause on each line. Immediate Cause (F) al disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tyes No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed? (es 24 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No 5 Residence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Manner of Death
 Manual 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

SUITE 200, GB, MD 21061

of death (Item 23a) (Type, Print)

32. Registrar's Signature

who completed cause

Year)

AUG

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, Set Hospital or Attending Physician: The law requires that the death certificate be executed by hours after death.

		Please 7	Type or Print in						jible.	
		For	State of Maryla				lental Hy	giene		
		1 - State Registrar		Ce	rtificate of	Death		Reg. No.	11/	2/000
Physici	an	Decedent's Name (First, Middle, Last	Elizabeth	Hutch	nins		2. Date of Dea Month	Day	Year	3. Time of Death
/Medic		4a. Facility Name (If not institution, give				r Location of Death	August		2007 ty of Death	6:40 P M
Examir	ier	Genesis Heritage				ndalk			altimo	
Funeral		Social Security Number 6. Se	x 7. Age (In yrs	. last birthday			8. Date of Birt (Month, Da	h	9. Birth	nplace (State or Foreign
Director		212-74-5966 Usual Residence of Decedent	Зм 2 区 F 85	Yrs.	Months Days	Tiours Willi.	Sept.	6,1921		nsylvania
/land ow et		10a. State 10b. County	10c. C	ity, Town or L	ocation					10d. Inside City Limits
a-f sh	tor	Maryland Balt	imore					Dundal	lk	1 □Yes 2 No
ith the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	f What Cou	untry?
s 23a		1102 North Point		10 140		21222		Unite		
ter de Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 ☑ No	J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	- 14. Ra	ace - Ameri ack, White	ican Indian, , etc.
urs af al", or Exam	þ	3⊠Widowed 4□Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Spec	ity:	White
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filed v Hygie ther t	ပ္ပို	6 Years 17. Father's Name (First, Middle, Last)		Ho	omemaker	18. Mother's Name	e (First Middle		Home	
ld be ental ked o ic eve	To Be	Earl Lamoreaux	ζ.			Lula W			imoy	
shou and M s mar	-	19a. Informant's Name/Relationship (7)		19b. Mail	ing Address (Street			er, City or Tow	n, State, Zi	ip Code)
and 2 ealth a n 27 is		Mr. Earl R. Hutchi			2 North P		Dundalk 	, Mary	land :	21222
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Gremation 3 ☐ F	20b. Removal from State	Place of Disp cemetery, cre	osition (Name of ematory or other plac		Date	20c. Location	- City or T	Town, State
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permi Depa Impo any I		21. Signature of Edmeral Service Licens	ee 8 /212	X	2. Name and Addre Duda-Ruck 7922 Wise	Funeral	Home of	Dunda:	lk, I	nc.
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Physician		Immediate Cause (Fin	he cause on each line.	PY	ARTE	RY D	ICE	APE		Interval Between Onset and Death
/Medical		disease or condition resulting in death)	aDue to (or as a conse	quenc of):	11-11-		1-1	17		10 (FIL
Examiner		Saxasoffally list conditions	= 1=88E1	TY	IALH	MYER	TEN	1 S10	N	30Y EARS
ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):		(•			•
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ith cer tendir ir use	an/I	Zob. Was decedent pregnant	23c. If yes, outcome pf pregr 1 ☐ Live birth 2 ☐ Fe		☐Ectopic pregnancy	v			ate of deliv	
ie dea the at ned fo	sici	in the past 1% months? 1 □ Yes 2 ☑ No 9 □ Unknown	4☐Pregnant at time of 9☐Unknown		Other (specify)	,		N	lonth	Day Year
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or Attending Physician: tfer death. Director: After this certifica in by the funeral director, in	ToE	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 [ER/Outpatie	nt 3□DOA Oth				ther (Spec	ify)
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ttend death. stor: /	icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury - At I	ome form of		Yes 2 □ No	00/ 1			
i or A after d Direction by	Certification:	4 Homicide determined	building, etc. (Spec		reet, factory, office		City or Tou		nber or Rui	ral Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Phy	sician: To the best of my kr	owledge, dea	th occurred at the tir	me, date and place,	and due to the	cause(s) and r	manner as	stated.
he Ho in 24 I he Fu pletel	Medical	(Check only 2 Medical Exami	ner: On the basis of examir and manner stated.	ation and/or i	nvestigation, in my o	opinion, death occur	red at the time,	date and place	e, and due	to the cause(s)
To t To t	Σ	29b. Signature and title of certifier	ingl		29c, Licens	e number		29d. Date sign	ed (Month	, Day, Year)
		a look	N	J.D	D	1416	1	11612	124	1,2001
9		30. Name and address of person who ex	emplered (auto of death (Ite	pegal/Tope	Pring 410	-ART	LCHIE	1+10	altv	JAY,
Sta	ite.	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature F	MA	KYLHI	ND 5	(22	7.	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month Mary E. Harry 23 2007 Aug. 7:40 a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hamilton Center Nursing Home Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F Yrs. **Director** 2<u>36-32-0733</u> 90 28, 1917 Tennessee Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2000No Director Maryland Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 2 must be n United States Funeral 2304 Oak Road 21219 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. "natural", or items 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 Is marked other the any injury or other traumatic event, the once. 10 years <u>Homemaker</u> Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Brown Rosie Loggins ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Charles Harry (Husband) Edgemere, Maryland 21219 <u>2304 Oak Road</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus 8/27/2007 4 Donation 5 D Other (Specify) Dundalk, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** END STAGE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as attending | | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Cther (specify) signed by the a ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ Wo 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe 2 -No or Attending Physician: Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 N 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident within 24 hours after death To the Funeral Director: completely filled in by the 1 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital twentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ATTENDING DO062235 MYSICIAN DR MAN NAING OO, NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 4000. Towsons St. MD 21204 31. Date filed (Month, Day, Year) AUG 2 9 32 Registrar's Signature State 2007 Registrar

07-06380 Claude Chester Ho	hod	Please Typ	pe or Print in tate of Maryla	Bla	ck Indeli	ble li	nk. Ensu Health a	re All C	opies <i>I</i>	Are Leg ene	gible.	0.0		~ wy = -
	1- R	For State			Certifica					Re	g. No.	2. U U		e of Death
Physician Medical Examine	er	Decedent's Name (First, Midd Claude Chester	r Hood				1) O'ly T		A	Date of Deat Month ugust 18	Oay , 2007	Year	010	06 hrs
	4	 a. Facility Name (if not institution Prince George's Hosp 		mber)			4b. City, Town, Cheverly	or Location o			Prir	nce Georg	je's	
Funeral Director	- 1	5. Social Security Number	6. Sex	7. Age 33	(In yrs. last birt	hday) Yrs		ear If Unde ays Hours	Min.	Date of Bir	27,1	974 Fore	irthplace ign Wa ountry)	Shington DC
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t. Pages tment o tment o rtaut: I		4 Opnation 5 Other 3	Specify:		Harmo		lemorial		2007	rt G.			-	ryland Home Inc
Ball permi Depar Impo	1	XXIIIXI	1100			16	61 Good	Hope	Rd SE	, Was	hingt	ton DC	200	20
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Examiner		Immediate Cause (Final diseas or condition resulting in death)							100					
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0, s be exec sician a burial - 1	edica	UNPENDED	AMENDED								234	Date of deliv	/erv	
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Inspital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.		IF FEMALE: 23b. Was decedent pregnant in past 12 months?	1 Live	birth	ne of pregnancy	2 F	Fetal death Other (Specify)	3 Ectop	ic pregnanc	у		Month	Day	Year
D. Bo t the dea by the a	죕	Part II. Other significant cond		nown to deat	h but not resulti	ng in the	underlying cau	ıse given in P	Part I.	23e. Did	tobacco u	se contribute	to the ca	use of death?
S, P.O. Lines that th signed by d be detach	ed by									1 Ye				4 Unknown findings available
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be in by the funeral director, page 2 should be in by the funeral director.	Completed	-				<u> </u>				auto perf		prior death	to comple	etion of cause of
tal R ian: T certifice	ğ B	25. Was case referred to medie examiner?	ical Hospital:		- 1772		p	Other;		ly one) Home 5	Resider	6 70	ther:	
of Vi	٤	1 Yes 2 No 27. Manner of Death	28a. Da	Inpation	ıry 28b	. Time o		Injury at Wor	rk? 2	8d. Describe	e how inju	ry occurred		
Sion Mtendin death. ector: A	Certification:		ending Aug 1		njury - At home,	05 hrs		Yes 2	No				Rural Ro	oute Number, City
Divisior Septral or Attend hours after death meral Director: y filled in by the	ertifi		ould not be		upr Store	iaini, su	eet, lactory, on			or Town.	State)	Sutland , N		
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the beasi	s of exa	ny knowledge, d mination and/o	eath occ r investig	curred at the times at the time	e, date and p inion, death o	place, and di occurred at t	ue to the car he time, dat	use(s) and e and plac	d manner as a ce, and due t	stated. o the cau	se(s)
To with To com	Me	29b. Signature and title of cert	and manner	1	/	·.		cense numbe	er			oate signed ust 18, 20		ay, Year)
		30. Name and address of pers)		D - W	MD 040	0.1				
<u>")</u>	ate	Jack Titus MD. Day, Yea	eputy Chief Med		xaminer ar's Signature	111 P	enn Street,	Baitimore.	, IVID 212	.01				

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Tonya Michelle Hetmanski

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		For State			C	ertific	ate of i	Death	}			Re	g. No.		
Physician		Decedent's Name (First, Middle	e,Last)								2.	Date of Death			3. Time of Death
Medical Examine			$\mathbf{T}^{\mathbf{c}}$	onya	Μ.	•	Hetma	ansk:	Ĺ			Month August 24,	Day Yea 2007		0943 hrs
	4	a. Facility Name (if not institutio 2801 5th Street	n, give stre	et and num	nber)		45		own, or Lo	ocation of int			4c. County of Baltimor		nty
Funeral	5.	Social Security Number	6. Sex	17	7. Age (in yr	s. last bir	hday)	If Unde	r 1 Year	If Under	24Hrs.	8. Date of Birt	n (MM/DD/YYYY	9. Birti	nplace (State or
Director		218-92-9456	1M		37		Yrs.	Months	_	Hours	Min.	Oct. 2	,	Foreign	
	-	sual Residence of Decedent			I.o. o										
v any	11	Da. State 10b. County			10c. C	City, Town	or Locatio	n							10d. Inside City Limits
shov shov	5	Maryland	Ba1t	timore	e					Sp	arro	ws Poi	nt .		1 Yes 2 X No
laryla	1	De. Street and Number						10f. Zip	Code			10	g. Citizen of Wh	at Coun	try?
the Maryland a or 28a-f sh tified at one	5	2801 5th Str	eet.						21219	9			United :	Stat	.es
s 233		1, Marital Status		Was Dece	dent Ever in	n U.S.		Deceder	nt of Hispa	anic Origi		cify Yes or No-	14. Race	- Americ	can Indian, Black,
r death with or items 23	<u> </u>	XX Never Married 2 M	arried 1	Armed For Yes	rces? 2XX N		If Yes	s, specify	Cuban, I	Mexican, I	Puerto Ri	can, etc.)	White	, etc.	
after death with the Maryland al", or items 23a or 28a-f she liter must be notified at once		Widowed 4 Div		s, Give Year		O	1	Yes 2	X No	specify:			Specify:	Wh	ite
urs afte		15. Decedent's Education (Spe	cify only hi	ates. ghest grade	e completed		Decedent's						16b. Kind of Bu	siness/Ir	ndustry
n "na al Ex	2 completed	Elementary/Secondary (0-12)		College (1-	4 or 5+)	 	during mo	st of work	king life. E	00 NO1 U	ise retired	1)			
036 thin he he ledic	림	12 Years				H	Iomema	aker		,			Own H	ome	
other N	3 1	7. Father's Name (First, Middle,	Last)						18	3.Mother's	Name (F	irst, Middle, N	Maiden Surname)	
215 be fill hall H rked ent, f		Joseph C. Hetr	nansk:	i, Sr	•					E1	eanc	or K. R	eed.		
ould ould a main s main s main evaluation out of the contract		9a. Informant's Name/Relations	hip (Type,	Print)		19	b. Mailing	Address	(Street	and Numb	er or Ru	ral Route Num	ber, City or Tow	n, State,	Zip Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland anent of Heath and Meintal Hygiene. The show are other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. The Bold Completed by Europea Director		Mr. Joseph C.	Hetma	anski									t., Mar	_	
Heal Heal	2	0a. Method of Disposition					of Disposit		e of ceme	etery,		Date	20c. Location -	City or	Town, State
nol hat: I		Burial 2 X Cremation Donation 5 Other S		kemovai tro			op Si		ce Co	orp.	8/2	28/2007	Towso	n, M	Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours. Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natur injury or other traumatic event, the Medical Exam	2			7 0			22 No	ame and	Address	of Eacility				7.1-	T
Per Per Military	-	1)2-(: a			-	7922	Wice	Δπε	, D	undalk	f Dunda Maryl	and	21222
Physician	2	3a. Part I. Enter the disease, or			used the de	ath. Do n	ot enter the	e mode o	f dying, s	uch as ca	rdiac or r	espiratory arr	est, shock, or he	art	Approximate Interval Between Onset and
/Medical	1.	failure. List only one cause mmediate Cause (Final disease	NT.		(meth	adone`) into	xicat	ion						Death
xaminer		or condition resulting in death)			consequence										
	. 5	Sequentially-list conditions,	b									7			
	<u>ā</u> i₁	fany leading to immediate ause. Enter Underlying Cause		to (or as a	consequent	ce of):								6.13	
	[] all	Disease or injury that initiated events resulting in death) Last	C	to (or as a	consequenc	ce of):									
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60, ate be hysic e bur	i led	F FEMALE:	2:	#23a.2 3c. If yes, o	27,28a-	regnancy	IE 68/	1,9/1	1/0/ 1				23d. Date of	delivery	/
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Box 68760, he death certificate be early the attending physician hed for use as the burian	Physicia	1 Yes 2 No 9 ✔ Un	known 4		ant at time o	of death	5 Oth	er (Spec	clfy)						
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ecc he lav ute ha	틹											perfo 1 ✓ Yes		death? ✓ Ye	es 2 No
n: T		25. Was case referred to medica	ıl					- :	26.Place	of Death (Check or	nly one)			
. G ∈ E ≤ Z	e Re	examiner? 1 ✓ Yes 2 No	Hosp	ital: 1 Ir	npatient 2	ER/C	Outpatient	3 D	OA C	Other ₄	Nursing	Home 5	Residence 6	✓ Other	r: Scene
of Physics Phy	- 17	7. Manner of Death		28a. Date ((Month,	of Injury	28b.	Time of in	ijury 2	28c. Injury	at Work	? 2	8d. Describe	how injury occur	red	
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r Atter de er de irecto	[일	- 37	stigation		e of Injury -				office bu	uilding, etc	c. 2			er or Ru	ıral Route Number, City
Divis Spital or A hours after meral Dire y filled in b	린		rmined	(Specify)	Found:	resid	lence					or Town, S 2801 5th	itate) St. Spar	rows	Point, MD
Hosp 24 hor Fune cely fi		0 0 110	hysician:					red at the	time, dat	te and pla			e(s) and manne		
thin 2 the mplet			miner:On		of examinati								and place, and		
£ . ½ £ . 8	₽ Z	9b. Signature and title of gertifi	r	/ // /	/			290	. License	number			29d. Date sign	red (Mo	nth, Day, Year)
		XIIIA	W	10					O.C.N	1.E.			August 25	, 2007	
d	2	80. Name and address of person	who com	pleted caus	se of death (Item 23a)			-						
9					al Exami		11 Peni	n Stree	et, Baltin	more, N	/ID 212	01			
Sta	te 3	31. Date filed (Month, Day, Year)		-	gistrar's Sig	nature	A. a.l	11							
Registra		AUG 2 9 2	2007	The same	ر سه	C 1	1	A. Walley							

Division or Vital Rec	To the Hospital or Attending Physiclan: The law within 24 hours after death.	To the Funeral Director: After this certificate has
2	To the Hospital or Attend within 24 hours after death.	To the Funeral Di
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	Please Type or Print in Black Indelible Ink. Ensure A State of Maryland / Department of Health and N 1 State	-	_	E w a lette
Physician	1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) ESSIE LENA JENKINS	2. Date of De Month	Day Year	3. Time of Death 9:50A M
/Medical Examiner Funeral Director	4a. Facility Name (If not institution, give street and number) 300 FARWIND DRIVE, APT. 3D 5. Social Security Number 217-20-1170 4b. City, Town, or Location of Death MIDDLE RIVER 7. Age (In yrs. last birthday) 1 Usual Residence of Decedent 4b. City, Town, or Location of Death MIDDLE RIVER 1 F Under 1 Year If Under 24 Hrs. 97 4b. City, Town, or Location of Death MIDDLE RIVER 1 F Under 1 Year If Under 24 Hrs. 4c. City, Town, or Location of Death MIDDLE RIVER 4b. City, Town, or Location of Death MIDDLE RIVER 4c. City, Town, or Location of Death MIDDLE RIVE	8. Date of Birt (Month, Da 9/16/		
Maryland -f show lied at	10a. State 10b. County 10c. City, Town or Location MD BALTIMORE MIDDLE RIVER			10d. Inside City Limits 1 □Yes ¾□No
th with the Mar 23a or 28a-f sl ist be notified	10e. Street and Number 300 FARWIND DRIVE, APT. 3D 21220		10g. Citizen of What Cou	ntry?
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. The Maryland is of Health and Mental Hygiene. The marked other than "natural" or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Y Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes Y No If Yes, specify Cuban, Mexican, Puerto If Yes, Specify Cuban, Mexican, Puerto If Yes, Specify: 1 Yes 2 No Specify:	pecify Yes or No o Rican, etc.)	14. Race - Americ Black, White, Specify: BLA	etc.
ed within 72 hou sygiene. t, the Medical E	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 7TH 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) COOK	king	16b. Kind of Business/In	
T and 2 should be filed with Heath and Mental Hygiene. em 27 is marked other than ther traumatic event, the N	PAYMUS JENKINS 18. Mother's Nam PAYMUS JENKINS BESS	SIE JEN	, Maiden Surname) KINS	
1 and 2 sho Health and em 27 is me	19a. Informant's Name/Relationship (Type. Print) DOTTERY C. OKORO / DAUGHTER 300 FARWIND DR., 20a. Method of Disposition 20b. Place of Disposition (Name of	APT. Date	er, City or Town, State, Zip 3D, MIDDLE 20c. Location - City or To	RIVER, M
t. Pa rtmer rtant: rjury	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Nother (Specify) ENTOMBMENT MEM GARDENS 9 / 0	1/07	MIDDLE RI	VER, MD
Physician	23a. Find the Wease, or complications that caused the de to Do not enter the mode of dying, such as cardiac shock, wheat follure. List only one cause on each line. Immediate Lause (Final disease or condition)	GIGHTS or respiratory ar	AVE., BALT	
eath certificate be executed attending physician and for use as the buriat-transit cian/Medical Examiner	resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			
nat the death certificate bd by the attending physic letached for use as the bear hysician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)		23d. Date of delive	ery Day Year
w requires that the de the earlies should be detached to should be detached the earliested by Physic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to t	
an: The law requii	25. Was case referred to medical 26. Place of Dea	1□ Yes	psy prior to co ormed? death? 2 No 1 □ Yes	opsy findings available impletion of cause of 2 M No
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examir	examiner?	ome 5 Resid	dence 6 Other (Special how injury occurred	
o the Hospital ithin 24 hours a o the Funeral ompletely filled	29a. Certifier (Check only one) 12 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place 21 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated.	rred at the time	date and place, and due to	n the cause(s)
To the within To the comp	and manner stated. 29b. Signature and title of certifier 29c. License number 29c. License number 23c. Name and address of person who completed cause of death (Item 23a) (Type, Print) MALK WILD 2 NORTH AVENUR BE AL 31. Date filed (Month, Day, Year) 22. Registrar's Signature AUG 2 9 2007	2	29d. Date signed (Month, August 78	Day, Year)
3 1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARK WILD 2 NORTH AVENUE BE A	R MA	ARTLANd	21014
State Registrar	31. Date filed (Month, Day, Year) AUG 2 9 2007 AUG 2 9 2007			

State of Maryland Bearmen of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Williams Physician Johnson 10:51AM 08 2007 27 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ' A Richey Baltimore Joseph 1
5. Social Security Number HOSpice Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. . Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) 1017 1934 **Funeral** 219.30.9916 Days 1 □ M 2 🗙 F Months Hours Min. MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Baltimore 1 Yes 2 □ No MD Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or North Glover Street 21205 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than ' Elementary/Secondary (0-12) Machinery 10th grade Operator or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosalee Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patterson Sandra Northway Drive Baltimore MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 05 07 injury 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaug hn C. Greene Funeral SUCS 21. Signature of Funeral Service Licensee York Road Battom Bre MD 2/2/2 MU1363 4905 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) LLATS /Medical Due to (or as a consequence of): Examiner slztlot (cisian Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? director, page 2 should be 3 Probably 4 ☐ Unknown 2 No 1 Tyes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 4☐ No 24a. Was an autopsy performe Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Hospice 1 Yes 2√ No Medical Certification: To completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral D 1 vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 27,2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Eutaw St Baltimore MD 21201 31. Date filed (Month, Day, Year) State AUG 2 9 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Johnson

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odney Jennings		State of Maryland / Department of		nd Ment	tal Hy	giene		201	17 2755
		1- For State Certificate of Registrar	Death		C		Reg. No.	1	
Physicia edical Examii	ш	Decedent's Name (First, Middle,Last)			ľ	2. Date of De Month August 2	Day	Year	3. Time of Death 1236 hrs
*		Rodney 4a. Facility Name (if not institution, give street and number) [4]	enning 4b. City, Town, o	s or Location o	of Death	August 2		ounty of Deat	
		Prince Georges Hospital Center	Cheverly		a*		Pri	nce Georg	je's
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Ye		r 24Hrs.	8. Date of B	irth(MM/DD)/YYYY) 9. B Fore	irthplace (State or
Director		216-92-7422 1XM 2 F 28 Yrs.	Months Da	ys Hours	Min.	01 2	25 7		ountry) MD
retuurus jakeren sa sastanken s	20	Usual Residence of Decedent							Table Trailer Charling
ow any		10a. State 10b. County 10c. City, Town or Locati							10d. Inside City Limits 1 X Yes 2 No
Maryland 28a-f show 1 at once.	ţ	MD NA Baltim 10e. Street and Number	ore 10f. Zip Code				10a Citizo	n of What Co	
ie Maryland or 28a-f sho Ged at once.	Director	ice. Sueet and number					rog. Citizei		
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eath w items	Funeral	1 Y Never Married 2 Married Armed Forces?	es, specify Cuba					White, etc.	moan malan, block,
fter d		3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2x N	lo specify:			S	pecify: E	Black
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5-0036 led within 72 tygiene. other than '	Compl		Disabl			· · · · · · · · · · · · · · · · · · ·			bled
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21215-0036 utdd-be filed within 7: Mental Hygiene. marked other than c event, the Medical	0	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	g Address (Stre	Bert	tha_ aber or Ri	Jenni ural Route Ni	Lngs umber, City	or Town, Sta	te, Zip Code)
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 Department of Health and Méntal Hygiene. Inportant: If Item 27 is marked other than "injury or other trauntatic event, the Medical Injury or other trauntatic event e		l l	Dulan						
e, Nand I and Heald		20a. Method of Disposition 20b. Place of Dispos	sition (Name of c			Date			or Town, State
more Pages 1 nent of H ant: If it		1 X Burial 2 Cremation 3 Removal from State crematory or oth 4 Donation 5 Other Specify: King Mem		Park	8/3	30/07	Ran	dalls	stown, Md
Baltimore, permit. Pages I ar Department of He Important: If ite		Signature of Funeral Service Licens + 22 N	Name and Addre	ss of Facility	<i>y</i>				
E P P E		Mullo C. Sun M 143	68hwE6	ashe:	st Ave,	Balt	imor	e, Mc	21215
Physician		23 Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	he mode of dyin	g, such as c	ardiac or	respiratory a	rrest, shock	c, or heart	Approximate Interval Between Onset and
/ /Medical xaminer	Ü	mmediate Cause (Final disease a. Multiple Injuries							Death
	1	or condition resulting in death) Due to (or as a consequence of):							
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ecuted and transit		events resulting in death) Last Due to (or as a consequence or):							
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ox 68760, eath certificate be excattending physician or use as the burial	sician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy					23d.	Date of delive	ery
Box 68760, e death certificate be the attending physic of for use as the bur	ian/	past 12 months?	etal death 3	Ectopi	c pregnar	ncy	l N	f onth	Day Year
eath c	sic	4 Pregnant at time of death 5 Ot	ther (Specify)				1		
t the d	Phy	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause	e given in Pa	art I.	23e. Did	i tobacco us	se contribute	to the cause of death?
ries that to signed by the detac	d by					1 Y	'es 2 🗸	No 3 Pr	robably 4 Unknown
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OCO le law le has ge 2 s	mp					per	formed?	death	?
tal Rec		25. Was case referred to medical	26.Pla	ce of Death	(Check o		2		Tes 2 No
Vita ysicia his cel direct	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient	t 3 DOA	Other ₄	Nursin	g Home 5	Residen	ce 6 Ott	ner:
of ing Ph	Η.	27. Manner of Death 28a. Date of Injury 28b. Time of	Injury 28c. In	njury at Work		28d. Describ			dumptruck
ion tendii tor: /	atio	1 Natural 5 Pending Aug 23, 2007 1030 hrs	1	Yes 2 🗸	No	Subject pe	euesii iai i	Struck by	dampiruok
Division ratendin rate death.	iific	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre	et, factory, office	e building, e	tc.	28f. Location or Town		d Number or	Rural Route Number, City
Spital sours a neral I	Certification	4 Homicide determined (Specify) Major Road / Highway	y		Į!	nner Loop	Beltwáy ex	xit 17, Land	over, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occu one) Medical Examiner: On the basis of examination and/or investigation.							
To t To c	Medical	and manner stated. 29b. Signature and title of certifier		nse number					Month, Day, Year)
	_	Mh. Brandom		C.M.E.				ıst 24, 200	
		30. Name and address of person who completed cause of death (Item 23a)							
3			Penn Street,	Baltimor	e, MD	21201			
		Loo Division Of State of Control	- M -						

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

Registrar
DHMH 17 Rev 1/2001

State

NILESH J. PATER MO

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ONE

SINAI HOSPITAL OF BALTIMORE

D 0064957

Hugust 26, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** ad/Medical 4a. Facility Name (If not institution, give street and number Examiner Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1 □ M 2 maruiand Director Usual Residence of Deceden 10d. inside City Limits death with the Maryland 10c. City. Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 □ No Funeral Director altimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Huenue Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No if Yes, Give Year or Dates: American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Baltimore, Maryland 21215-0036 Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be ဥ lanh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore 20b. Place of Disposition (Name of cemetery, crematory or other place) 100 mD 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State All Saints Church 08.31.07 Theisterstain, mo 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8728 Liberty Bd Mondaustain mo Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical detached for use as the IF FEMALE: if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ funeral director, page 2 should be 4 Unknown 2 □ No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital 2 ER/Outpatient 3 DOA 2 No 1 🗌 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tyes Medical Certification: To 27. Mann T Death 28c. Injury at Work? 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred After (Month, Day Year) Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No o 24 hours after death.

Funeral Director: A letely filled in by the fu death. 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person

State

Registrar

31. Date filed (Month, Day, Year)

AUG

29

2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Augur 27 **Physician** VAISY 5:03P LARUTH. 2007 JUHNSON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Touson BALTIMURE HOLLY HILL MANOR If Under 24 Hrs. 8. Date of Birth (My311/, 28/, 1991) 1 9 If Under 1 Year Birthplace (State or Foreign TN Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days 374-18-8683 1□M 2**2**5 Yrs Director Usual Residence of Decedent se filed within 72 hours efter death with the Maryland el Hygiene. other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylar Depertment of Health end Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinet must be notified at once. 1 ☐ Yes ≥ No Columbia MD Howard Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21045 5657 Lightspun Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Bleck, White, etc. ☐ Yes 2☐No Yes, Give 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Own Home 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last)
John Henry Kennedy 18. Mother's Name (First, Middle, Maiden Surname)
Nancy Bailey Be Nancy ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5657 Lightspun Lane Columbia, MD 21045 19a. Informant's Name/Relationship (Type, Print)
Yaseen Mahmud/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Carmel Cemetery 20a. Method of Disposition Adde 30 20c. Location - City or Town, State 2007 Baltimore, Maryland 1. Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee & remard of card Früheral Alternatives MO1443 8717 Green Pastures Drive Baltimore, Maryland 21286-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) a. End Staye Kidner Disease
Due to for as a consequence of): /Medical Examiner Physician/Medical Examiner Diabeter Mellitur. Attending Physician: The lew requires that the death certificate be executed use es the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated even injury) Due to (or as a consequence of): and ivision of Vital Records, P.O. Box 68760, attending physician that initiated events resulting in death) Last Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? After this certificate has been signed by the a funeral director, page 2 should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably W Unknown 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ۵ 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 1 Naturel 2 Accident 5 Pending investigation To the Hospital or Attending within 24 hours effer death.

To the Funerel Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif . 17041

State Registrar

ma) I. Leaver Marc 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

1205 York Road Ste 38 Lutpaville no)

DHMH 16 Rev 6/95

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Syprian Lamar J		SON 1- For State Registrar	State of	f Maryland / Dep <i>Ce</i>	artment of ertificate of			Hygi		. N o.	έU.	17 2755
Physicia	an/	1. Decedent's Name (First, M	iddle,Last)	T. 11.					ate of Death	Day	Year	3. Time of Death
Medical Exami	ner	4a. Facility Name (if not insti	ama	r Jachso	n	4h City To	wn, or Location of De	A	ugust 20,	2007	ounty of Dea	0759 hrs
		Sinai Hospital	ution, give s	reet and number)		Baltimo		atti		70.00	ounty of Dea	ui
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under			Date of Birth	(MM/DD/	YYYY) 9. B	rthplace (State or
Director		213-98-3131	1 M	2 F 2	8 Yrs	Months .	Days Hours M	Min.	1/10/	197	9 Fore	ountry) Md
any		Usual Residence of Deceder 10a. State 10b. Cou		Inc. Cit	y, Town or Locat	ien						10d. Inside City Limits
<u> </u>		MA 100.000	ity	100. 01	Baltin)					1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number		(()	Culti	10f. Zip C	Code	-	100	g. Citizen	of What Co	untry?
hours after death with the Maryland 'natural'', or items 23a or 28a-f she Examiner must be notified at once	ä	2025 1310	hu	ood Clicen	me	a	11207			6	LSA	
th with ems 2.	Funeral	11. Marital Status 1 Never Married 2	Married 1	Was Decedent Ever in I Armed Forces?			t of Hispanic Origin? (Cuban, Mexican, Pue			14.	Race - Ame White, etc.	rican Indian, Black,
er dea			· .	1 Yes 2 No Yes, Give Year			No specify:			Sou	ecify: \nearrow	loc 16
0036 within 72 hours afte iene. er than "naturial", Medical Examiner	d by	15. Decedent's Education (0	r Dates:	16a. Deceder	nt's Usual O	ccupation (Give kind	of work	done		of Business	Industry
· · · · · ·	Completed	Elementary/Secondary (0-	12)	College (1-4 or 5+)	during m	ost of work	ing life. DO NOT use	retired)	- 1	N:	onh	1001
5-0036 Iled within 72 Hygiene. Joher than *	ошь	17. Father's Name (First, Mic	dlo Last)			J13(18.Mother's Na	me /Fir	st Middle Ma	aiden Su	Jame)	eol
	BeC	Me Will To	r ih	in. TR			1 Cadi	ni	Con	ny	L	
D 2121 should be f and Mental 7 is marked	To	19a. Informant's Name/Relat	onship (Typ	e, Print)	19b. Mailin	g Address	(Street and Number	or Rural	Route Namb	er, City o	or Town, Sta	te, Zip Code)
, MD and 2 shot eath and tem 27 is traumatic		20a. Method of Disposition	<u>acinsi</u>	n (mother)	Place of Dispos	5 01	ch waal	Uy	C. Bai	41MA 20c. Loc	ation City	1 <u>d d 136-</u> / or Town, State
Nore, ages 1 a nt of He t: If ite			ition 3	Removal from State	crematory or ot		Const.	2/2	1/1-	11/6	ations city o	n rown, state
Properties or	100	4 Donation 5 Othe 21. Signature of Funeral Ser		e 4 /	100010	Vame-abal A	ddress of Frollity)/3	10/	MOC	M/au	1/110
Balt permit Depart Impor injury		Vauahn	Cx	Gune,	51	LUMIN KI BA	Himne	MI	Dunc	2 Hn	MAN L	m/2/209
Physician		23a. Part I. Enter the disease failure. List only one ca	, or complica	ations that caused the deat	h. Do not enter t	he mode of	dying, such as cardia	ac or res	piratory arres	st, shock,	or heart	Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final dise	ase a. G	unshot Wound of He	ad with Com							Death
		or condition resulting in deat	'') Du b.	e to (or as a consequence	of):							
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ca		e to (or as a consequence	of):							
	Examiner	(Disease or injury that initiat events resulting in death) Li	ed ^{C.} —	e to (or as a consequence	of):			_				-
be executed sician and urial - transit			d									
	edical	UNPENDED		AMENDED						_		<u> </u>
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bur	5	IF FEMALE: 23b. Was decedent pregnant past 12 months?	in the	23c. If yes, outcome of pre		etal death	3 Ectopic pre	gnancy			oate of delive onth	ery Day Year
or use	sicia	1 Yes 2 No 9	Unknown	4 Pregnant at time of o	death 5 O	ther (Specia	fy)					
D. Be the de by the iched f	Phys	Part II. Other significant co		9 Unknown ontributing to death but not	resulting in the	underlying o	cause given in Part I.		23e. Did tob	acco use	contribute t	to the cause of death?
ords, P.O. B w requires that the d s been signed by the	d by							_	1 Yes	2 🗸 N	lo 3 Pr	obably 4 Unknown
rds, requir	lete								24a. Was ar autops			autopsy findings available completion of cause of
(eco he law ate has	Completed							_	perform	ned?	death?	
Vital Rec ysician: The I his certificate I	BeC	25. Was case referred to me examiner?				26	6.Place of Death (Che	eck only	one)			
Physic rathis or	ျ	1 Yes 2 No 27. Manner of Death	Hos	ipital: 1 Inpatient 2	ER/Outpatient			rsing H	ome 5 F	Residence		er:
Division of Vital Records, tal or Attending Physician: The law require rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should b	ion:	1 Notural	Pending	28a. Date of Injury (Month, Day Year) Feb 15, 2000	28b. Time of 2256 hrs	injury 126	3c. Injury at Work? 1 Yes 2 ✔ No	ISH	pject shot		occurred	
risic r Atter er dea irector	ficat	2 Accident	nvestigation Could not be	28e. Place of Injury - At	home, farm, stre	et, factory,	office building, etc.	28f			Number or f	Rural Route Number, City
Divisospital or A hours after meral Direct by filled in b	Certification:		letermined	(Specify) Local Stre	eet			250	or Town, Sta 0 Madison a	^{ate)} Ave, Ba	ltimore, MI	
Fo the Hospital within 24 hours: To the Funeral completely filled		Chlock May		: To the best of my knowle								
To the I within 2 To the I complet	Medical	29b. Signature and title of ce	aı	n the basis of examination nd manner stated.	and/or investiga		License number	ou at tile	, ame, date a			tne cause(s)
		and the of ce		0 111			O.C.M.E.				st 21, 200	
2		0. Name and address of pe	son who cor	mpleted cause of death (Ite	m 23a)							
2		Laron Locke MD.		nt Medical Examiner		Street,	Baltimore, MD 2	21201				
S	ate	31. Date filed (Month, Day, Y	ear)	32. F gistrar's Signa	ture	and !						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Otato of Marylo	Cei	tificate of l	Death	R	eg. No.	107	27664
	Physicia	an	1. Decedent's Name (First, Middle, La LUCILLE E . K					2. Date of Deat Month	Day	Year	3. Time of Death
	/Medic	al	4a, Facility Name (If not institution, giv			4b. City, Town, or	Location of Death	AUG.	24 20 4c. Count	07 ty of Death	3:00A M
Jr.	Examin	er	AUGSBURG LUTHE			GWYNI	J OAK If Under 24 Hrs.			LTIMO	DRE
	Funeral Director		117-20-3337	Sex 7. Age (In yi	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 6 / 29 / 1	Year)	Coun	lace (State or Foreign try) YLAND
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	cation				10	0d. Inside City Limits
	e Mary ta-f sh tified	ctor	MD N/A		BAL	TIMORE	CITY				1 Yes 2 □ No
	with th a or 28 be no	Director	10e. Street and Number 4203 CHATHAM	ROAD		10f. Zip Code	207	1	0g. Citizen of	f What Coun	try?
	ms 23	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.		ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-		ace - America	
036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hyglene. I Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ XWidowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 X ☐ No		Thour, etc.,		ify: BLA	
215-0036	72 hc "natur	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece (Give	dent's Usual Occup kind of work done o DO NOT use retired	eation during most of work d)	ing	16b. Kind of I	Business/Inc	lustry
212	withir jene. r than the Me	ошо	Elementary/Secondary (0-12) 12	College (1-4or 5+)	1	IBRARIA			E	DUCA	rion
	be filed stal Hyg d othe event,	BeC	17. Father's Name (First, Middle, Las				18. Mother's Name	•		ıme)	
Maryland	should nd Men marke ımatic	은	WAVERLY MOR 19a. Informant's Name/Relationship		19b. Maili	na Address (Street	AATIE and Number or Run	LUE HI		n, State, Zip	Code)
	and 2 sealth an n 27 Is		ARDELIA LOKEM	AN / SISTER			AN ROAD,	BALTI			
Baltimore,	Pages 1 annent of Hearnnt: If Item		20a. Method of Disposition 1X Burial 2 □ Cremation 3 [4 □ Donation 5 □ Other (Special Content of the content	Removal from State (ify)	p. Place of Dispo cemetery, cre RBUTUS	osition (Name of matory or other place MEM . P.	ARK 8/29	Date 9 / 07	BALTI	•	CO., MD
Balti	permit. Pages Department of Important: If it any injury or o once.		21. Signatur Ineral Service Lice	10.00	Ol 4	600 LIB	ERTY HEI	GHTS A	VE.,		ME 21207 IMORE, MD
68760,	Physician // // // // // // // // // // // // //	ledical Examiner	23a. P.M. En r the disease, or cor snock, or heart failure. List only Imm to Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last	a. Due to (or as a cons Due to (or as a cons Due to (or as a cons c. Due to (or as a cons d.	sequence of):	ecute	. Cu d	OVAS	cula	Desc	Approximate Interval Between Onset and Death
.O. Box	The law requires that the death certific te has been signed by the attending page 2 should be detached for use as.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	⊒Ectopic pregn <i>a</i> nc ⊒ Other <i>(specify)</i> _	у			Date of delive Month	ery Day Year
Ω.	w requires that been signed b should be deta	þ	Part II. Other significant conditions Diabete	/ // \	resulting in the u	inderlying cause giv	ven in Part I.		obacco use co ⁄es 2 No		he cause of death?
Records,	The law recate has bee page 2 sho	Completed								b. Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of 2 No
or Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Dear				
0	Physic r this carrial dire	<u>은</u>	1 Yes 2 11 10 27. Manne Death	28a. Date of Injury	2 ER/Outpatie	III 3 LI DOA	4 Nursing He	ome 5 Residence 128d. Describe 1			ý)
ion	Attending F r death. ector: After by the funer	ation	1 atural 5 ☐ Pending 2 ☐ Accident investigation		r) Injury		rk?]Yes 2 □ No				
Division	al or Atte s after des al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		at home, farm, st ecify)	reet, factory, office		28f. Location (5 City or Tov		mber or Rura	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier 1 ertifying F (Check only one) 2 Medical Ex-	Physician: To the best of my aminer: On the basis of exan and manner stated.	knowledge, dea nination and/or i	nvestigation, in my	opinion, death occu	, and due to the rred at the time,	date and plac	ce, and due t	to the cause(s)
	To the Comp	Ž	29b. Signature and title of ertifier	20		29c. Licens		- I	29d. Date sig		
,	7		30. Name and address of person wh	o completed cause of death /	Item 23a) (Tyne	Print)	0//	5	1-7"	/\ 2	-0,200)
5			2835 5~ h	Aus Fara	っしり	BOBM	10 Sn	ide 2	2031	BALT	28,200) invisor
	St Regist	ate rar	31. Date filed (Month, Day, Year) AUG 2 9 20	32. Registrar's S	ignature	W					

3. Time of Death Year 200
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9. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Yes 2 No What Country? See - American Indian, ook, White, etc. White usiness/Industry
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1500 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Edward James Kennedy August 25, 2007 /Medical 2:45 A 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Timonium Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Year)
May 22, 19 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Days 1 X M 2 □ F 509-46-5303 Director 89 1918 Ohio Usual Residence of Decedent death with the Maryland 10b County 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh notified Baltimore Maryland 1 TYes 2KINo Owings Mills Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 9913 Middle Mill Drive USA by Funeral 21117 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 21215-0036 1 ☐ Yes 2 No White 3 Widowed 4 Divorced Specify: er than "nature , the Medical F 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hydrologist US Geological Survey Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Winifred Appelgate John Francis Kennedy ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Kennedy 9913 Middle Mill Drive; Owings Mills, MD 21117 Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify)

21. Signature of uneral Service signature All Saints Cemetery 8/29/2007 Reisterstown, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, M01290 23a. Part1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart value. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐ Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 2X No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 0 HOSPICE 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 2300 DULANEY VALLEY RD. DR. TARIQ MAHMOOD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

AUG 2 9 2007

AUGUST

07-06542

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Arie	ne Mika Lipo		1- For State	tate of Marylar	Cert	ificate of			Reg	. No. 201	7 2756
Me	Physici dical Exami		Decedent's Name (First, Mid	dle,Last) Arlene I	1	24			2. Date of Death Month August 23,	Day Year 2007	3. Time of Death 1733 hrs
A Comment of the Comm			4a. Facility Name (if not institut 7905 Mt. Pleasant C	ion, give street and num			4b. City, Town, or Lo Walkersville	ocation of Death	:	4c. County of Dea Frederick	th
	Funeral Director		5. Social Security Number 189-38-2786	6. Sex 7	'. Age (In yrs. la:	st birthday) O Yrs	If Under 1 Year If Under 24H Months Days Hours Mi		8. Date of Birth	(MM/DD/YYYY) 9. B Fore	
	ow any.		Usual Residence of Decedent 10a. State 10b. Count		10c. City,	Town or Locat			• ,		10d. Inside City Limits 1 Yes 2 X No
3	Maryland r 28a-f sho	Director	10e. Street and Number	ederick		Wa	10f. Zip Code	<u> </u>	109	g. Citizen of What Co	
0	after death with the Maryland al", or items 23a or 28a-f show ner must be notified at once.	Funeral D	11. Marital Status Never Married 2	Married Armed For	dent Ever in U.S ces?		2 17 as Decedent of Hispa es, specify Cuban, M	anic Origin? (Sp		14. Race - Ame White, etc.	erican Indian, Black,
	urs after de tural", or aminer mu	ò	3 Widowed 4 D	1 Yes ivorced If Yes, Give Year or Dates: ecify only highest grade	2 × No	16a. Deceder	Yes 2 🔀 No	n (Give kind of w		Specify: Wr	
	Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", in jury or other traumatic event, the Medical Examiner.	Completed	Elementary/Secondary (0-12	5	1 or 5+)	during m	Social V	Vorker		Sucial	Work
PA 1	1215-0 d be filed v fental Hygi rarked oth	o Be Co	17. Father's Name (First, Middle John 19a. Informant's Name/Relation	M. Mattie		Tion Mailin				eiden Surname) Marko per, City or Town, Sta	to 75 Code)
	MD 2 2 shoul h and N 27 is m	Ţ	James L. Lipo				,			er, city or Town, Sta	
	nore, lages I and suit of Healint: If item		20a. Method of Disposition 1 Burial 2 Crematic 4 Donation 5 Other	on 3 Removal from	20b. P m State	lace of Dispos ematory or ot	sition (Name of ceme	etery,	Date	20c. Location - City	or Town, State
	Baltir permit I Departme Importa		21. Signature of Funeral Service Zausa C. Wa	e Licensee		22. N	Name and Address o	f Facility Ard	lent Crem	ations	10 21076
′	Physician /Medical xaminer	ļ.	23a. Part I. Enter the disease, failure. List only one caus Immediate Cause (Final diseas or condition resulting in death)	e on each line.	tion	Do not enter t	he mode of dying, su	uch as cardiac or :	respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
	bd ssit	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	consequence of)	ulcerat	icated by d	rug induce	ed esophae	itis with	
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	cath certific eath certific attending p	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U	the 23c. If yes, of	atcome or pregn th nt at time of dea	ancy 2 Fe	etal death 3 her (Specify)	Ectopic pregna	ncy	23d. Date of delive Month	ery Day Year
	, P.O.	ρ	Part II. Other significant conc Kidney disea	ū	death but not re	sulting in the i	underlying cause giv	en in Part I.		2 ✓ No 3 Pr	to the cause of death?
	iof Vital Records, P.O. Bing Physician: The law requires that the d After this certificate has been signed by the inneral director, page 2 should be detached	Completed							24a. Was a autops perform	y prior to ned? death?	
	Vital ysician: his certif director,	o Be	25. Was case referred to medic examiner? 1 ✓ Yes 2 No	(Hospital:	patient 2 1	ER/Outpatient	- 10	f Death (Check of ther 4 Nursing		Residence 6 🗸 Oth	ner: Scene
MUCCO IT		ation: T	27. Manner of Death 1 X Natural 5 Pe	28a. Date o (Month, I nding estigation	f Injury Day,Year)	28b. Time of I		at Work? s 2 No	28d. Describe h	ow injury occurred	
2	Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: /	Certification:	3 Suicide 6 Co	uld not be ermined (Specify)	of Injury - At ho	me, farm, stre	et, factory, office bui	lding, etc.	28f. Location (Stor Town, Stor		Rural Route Number, City
+	To the Hospital within 24 hours a To the Funeral completely filled	Medical (Orioon only	Physician: To the best aminer:On the basis of and manner sta	examination an						
	L % H &	Me	29b. Signature and title of certification	fier			29c. License O.C.M			29d. Date signed (A August 24, 200	- '
1)	7 00	ME	30. Name and address of person Mary G. Ripple MD.	on who completed cause Deputy Chief M			1 Penn Street, I	Baltimore, M	D 21201		
V	S	ate	31. Date filed (Month, Day, Yea		istrar's Signatu	. Ace	de				

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

7601 OSLER DRIVE

32. Registrar's Signature

TOWSON, MARYLAND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LIM

BOON POH

AHG 2 9 2007

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 100 d 14 per fth 8870 8-29-07 vt Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Mirza Afzal August 28 2007 7:10p. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Woodstock Howard 3326 Peddicoat Ct. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours **X**□ M 2□ F 71 30 Pakistan 06 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 □Yes 2√ No Directo Woodstock MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pakistan Pakist 21163 Funeral 3326 Peddicoat Ct 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White etc. Pakistani 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No þ Specify: Pakisitan 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 12th grade 6+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mirza Altaf Baig Ijaz Begum 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3326 Reddicoat Ct, Woodstock, Md 21163 Rashid Afzal-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King_Memorial Park 8/29/07 Randallstown, 21. Signature of Funeral Service Licens 22. Name and Address of Facility 23a. Part1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. March F/H West 4300 Wabash ave, Baltimore, Md Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed?

1 Yes 2 400 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Tes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

attending physician and for use as the burial-transit The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, signed by the a certificate has t irector, page 2 s the Hospital or Attending Physician: funeral director. After this s after dea. filled in by To the Hosp within 24 hor To the Fune completely f

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show unit. If New 197 is marked other than "natural", or Items 28 or 28a-f show unit or other traumatic event, the Medical Examiner must be notified at

Department of Health ar Important: If Item 27 Is any injury or other trau

Physician /Medical

Examiner

Baltimore, Maryland 21215-0036

State Registrar

SHA HWA 31. Date filed (Month, Day, Wear)

29b. Signature and title of certifier

> S. Suddigi ND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIDDIRE





29c. License number

D30119

29d. Date signed (Month, Day, Year)

SYKESVILLE 21784

8-29-07

RUAL

AUGUST 25, 2007	Baltimore, Maryla
•	No.
(O. Box 68760, 🕏

ETTA MOHN

		State Registrar		Ce	rtificate of	Death		Reg. No.		27671
Physicia /Medic		1. Decedent's Name (First, Middle, L Etta C Mohr	ast)				2. Date of De Month August	25 Day 2007	Year	3. Time of Death 12:30 P M
Examin	_	4a. Facility Name (If not institution, g	ive street and number)			or Location of Death	1	4c. Coun	ty of Death	
- uneral Director		Stella Maris 5. Social Security Number 215 34 6200	Sex 1□M 2 X F 93	e (In yrs. last birthday) Yrs.	Towson If Under 1 Year Months Days		8. Date of Bir (Month, Da	rth	9. Birthp Coun Baltir	lace (State or Foreign try) nore City, MD
		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation					0d. Inside City Limits
27 is marked other than "natural", or items 23a or 28a-f show it traumatic event, the Medical Examiner must be notified at	힏	Maryland Baltimor	e	Baltimore (1	1 □ Yes 2 ☑ No
or 28a e notii	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	What Coun	try?
nust b	eral	9112 Lennings Lane	12. Was Decedent	Eury in II C 12	21237	Ulcannio Origin? (C	positu Vos or No	USA	ace - Americ	an Indian
ЕХАППЕ		11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces?	10	was Decedent of If Yes, specify Cul 1 ☐ Yes XX No	Hispanic Origin? (S ban, Mexican, Puerl o <i>Sp</i> ec <i>ify:</i>	to Rican, etc.)		ack, White,	etc.
Medical I	Completed by	15. Decedent's (Specify only highest statementary/Secondary (0-12)	Education trade completed) College (1-4or 5	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of war	rking	16b. Kind of		
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other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, La August J Thiess		10h Maili	na Addrana (Straa	18. Mother's Nar Annie Ger	lœk			Code
traun		19a. Informant's Name/Relationship Elaine Roberts	(туре. Рппт)	I	,	<i>a</i> ne Baltin				Codej
any injury or other		20a. Method of Disposition	CD	20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ace)	Date	20c. Location	- City or To	wn, State
jury o		1 N Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	cify)	Zion Cemet		st 29 2007		Baltimon	e, Mar	yland
any in		21. Signatule of Funeral Service Lic	reson		401 Relair		timore, M		21236	
attending physician and indicate as the burial-transit for use as the burial-transit and indicate as the burial transit and indicate as the burial transit and indicate and indicate as the burial transit and indicate as the bur	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of): a consequence of): a consequence of):	FAILURE					Onset and Death
sched for use a	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 [⊒Ectopic pregnan ⊒ Other (specify)	су			eate of delive Month	ery Day Year
be detached f	by Pt	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	ınderlying cause g	iven in Part I.				ne cause of death?
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nis certificate I director, pag	Be C	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only	2 ∑ No one)	10163	2010
After this funeral dii	은	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Inju (Month, Da	ent 2 ER/Outpatie ry y Year) 28b. Time o Injury	of 28c. Inj			idence 6 X C		HOSPICE
To the Funeral Director: completely filled in by the i	Certification:	3 Suicide 6 Could not determine		ury - At home, farm, st c. (Specify)	reet, factory, office	9	28f. Location (City or To	(Street and Nur bwn, State)	nber or Rura	il Route Number,
completely filled in	Medical (Physician: To the best aminer: On the basis o and manner st	f examination and/or in						
mp duo	Me	29b. Signature and title of certifier)		29c. Licer	nse number		29d. Date sign	ned (Month,	Day, Year)
F 8					1 / 1 /	1372		-	1 . /	

07-06554 Gregory McCray

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

201	07 2767	70.11
Year	3. Time of Death 0840 hrs	
unty of Death	A	
Eoroic	ountry) Md	
	10d. Inside City Limits	A-111 W
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Race - Amer White, etc.	rican Indian, Black,	
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d Ba	alto. Hotel	
less	e Zin Code)	

	1- Fo	or State	C	ertificate of D	Death		Reg.	No.	
Physician/ **Mical Examine	1. D	ecedent's Name (First, Middle,Las	McCr	au			Date of Death Month D August 24, 2		3. Time of Death 0840 hrs
		Facility Name if not institution, giv Maryland General Hospita		1	City, Town, or Baltimore	Location of Death	¥	4c. County of Deat	A
Funeral Director	2	ocial Security Number 6. St 5-60-5732	1-1	s. last birthday) / Yrs.	If Under 1 Yea Months Day		8. Date of Birth(Forei	thplace (State or gn buntry) Md,
Maryland 28a-f show any, d at once.	10a	al Residence of Decedent State 10b. County Street and Number	A 10c. C	Bath	more)	10g	. Citizen of What Cou	10d. Inside City Limits 1 Yes 2 No Intry?
with the Maryland ns 23a or 28a-f sho be notified at once		936 W. N Marital Status	12. Was Decedent Ever in			spanic Origin? (Sp			rican Indian, Black,
s after death with right, or items 23 niner must be no they Furneral	3		1 Yes 2 No	1 Y	es 2 🔀 No			White, etc. Specify: B	acK
36 in 72 hour han "natu lical Exan		6. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. Decedent's during mos	Usual Occupa t of working life	ation (Give kind of web. DO NOT use retire)	red)	Local R	alto, Hotel
215-0036 be filed within 72 ntal Hygiene. rked other than rent, the Medical		Father's Name (First, Middle, Last	-ugone	McCro	y	18.Mother's Name	ley +	Anders	Son
- P = E E	M	i. Informant's Name/Relationship (NS. Shirley Method of Disposition	McCray	19b. Mailing A	Penns	vlvanio	Rural Route Numb	er, City or Town, State 109 Balta 20c. Location - City of	o. Md. 21201
Pages I ment of H tant: If i	1 4	Burial 2 Cremation 3 Donation 5 Other Specifi	Removal from State	orematory or othe		8/3	30/2007	Lansdi	wne, Md.
Balti Departm Importa	1	Signature of Funeral Service Lice	plications that consed the de	1/ 22	eph L	North	Funera ve. Ba r respiratory arres	Homa st, shock, or heart	Approximate Interval
/Medical xaminer		filure. List only one cause on e mediate Cause (Final disease a condition resulting in death)	Liver failure a Due to (or as a consequence		intoxica	ntion			Between Onset and Death
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760, icate be executed physician and the burial - transit	ᄝᆢ	X UNPENDED FEMALE:	AMENDED #23a,27,28a-f	perME.g871	. 9/27/C	7 TT		23d. Date of delive	erv
Box 68760, e death certificate but the attending physic ed for use as the but	1 Pa	. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of	2 Feta	al death 3 er (Specify)	Ectopic pregna	ancy	Month	Day Year
P.O. Es that the configured by the detached	2	rt II. Other significant conditions	contributing to death but n	ot resulting in the un	derlying cause	given in Part I.			to the cause of death?
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certificate Hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed							y prior to ned? death'	autopsy findings available o completion of cause of ? Yes 2 No
ital sician: is certifi irector,	$ \mathbf{p} ^{25}$. Was case referred to medical examiner?	Hospital: 1 ✓ Inpatient 2	ER/Outpatient		Other Nursi		Residence 6 Oth	ner:
on of V nding Phys th. r: After thi	27 1	. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of In	jury 28c. In	jury at Work? Yes 2 X No	28d. Describe h	ow injury occurred	
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director - After this certif completely filled in by the funeral director.	Certification:	Accident Investigation Suicide 6 X Could not determine	28e. Place of Injury -		t, factory, office	building, etc.	or Town St	ate)	Rural Route Number, City
To the Hosp within 24 ho To the Fune completely fi	29	a. Certifier 1 Certifying Physineck only 2 Medical Examin	cian: To the best of my know er:On the basis of examination and manner stated.	vledge, death occurre on and/or investigation	ed at the time, on, in my opinio	date and place, and on, death occurred	d due to the cause at the time, date a	and place, and due to	the cause(s)
F 3 F 3	29	b. Signature and title of certifier Wouyoute The	Youle		ĺ	nse number C.M.E.		29d. Date signed (# August 25, 200	
04	30	. Name and address of person wh	Assistant Medical Exa	miner 111 Pe	enn Street,	Baltimore, MD	21201	OCM.	
Sta	31	. Date filed (Month, Day, Year)	32. Regisar's Sig	nature .	Cart.			UUM	-

AUG 2 9 2007

Registrar

		_	For State Registrar	State	of Marylan		irtment of tificate of	Health and <i>Death</i>	Mental Hy	/giene (Reg. No.	007	27672
Р	hysici	an	Decedent's Name (First, Middle D 111						2. Date of D Month	Day	Yeer	3. Time of Death
	/Medic	al	Billy Lee Moor						August		2007	20:00 M
E	Examin	er	4a. Facility Name (If not institution Ft Washington	-	umber)		Ft Wash			Pr	County of Death ince Geo	-
	ineral ector		5. Social Security Number 578–90–8540	6. Sex 1 ★ M 2 □ F	7. Age (In yrs. 51	last birthday) Yrs.	If Under 1 Yea Months Days			irth 19 lay, Year) per 2	9. Birthy Cou Sout	place (State or Foreign ntry) .h Carolina
1215-0036 within 72 hours after death with the Maryland ene.	"naturel", or Items 23a or 28a-f show allcal Eva , it er roust be notified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince 10e. Street and Number 100.2 In and an Pool			y, Town or Lo Washin	gton 10f. Zip Code				en of What Cou	•
36 s after death v	, or Items 23a a . it er must	by Funeral	903 Jessica Dri 11. Marital Status 1∑ Never Married 2□ Marri	12. Was Dec Armed F ed 1 _Yes If Yes, G	2XINo iive	Ji	20744 Vas Decedent of Yes, specify Cu	Hispanic Origin? (ban, Mexican, Pue	(Specify Yes or Nerto Rican, etc.)	0- 1	d State 4. Race - Ameri Black, White, Specify: Blace	can Indian, etc.
21215-0036 d within 72 hours af giene.	od other than "naturel" event, it e Madical Ev	Completed b	3 Widowed 4 Divorced 15. Decedent (Specify only highes Elementary/Secondary (0-12)	t grade completed		(Give life. L	OO NOT use retir	e during most of w ed)	rorking		d of Business/Ir	dustry
N po	other t vent, II		Unknown 17. Father's Name (First, Middle, I	act)		Groun	ds Keep	· T · · · ·	ame (First, Middle	1	etery	
Maryland Id 2 should be file tth and Mental Hy		To Be	Joe Miles						eth Moore		surrianie)	
Mar nd 2 sho alth and	on 3		19a. Informant's Name/Relationsh Elmore Moore/Un					enue, Hya				
Baltimore, M bermit. Pages 1 and 2 Department of Health	it: If item y or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Doylation 5 ☐ Other (S)			Place of Disponentery, cremotery, cremotery	sition (Name of natory or other pl Park	Augu	ust 28,		eation - City or Tordale, M	own, State faryland
Baltir permit. P Departme	Importent: If its any injury or of once.		21. Signatule of Fineral Service						bert G.	Masor	Funera	1 Home Inc
/Me Exar	physician and cities burial-transit the burial-transit	Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to	each line.	uence of):	er the mode of dy	ing, such as cardi	pathy	arrest,		Approximate Interval Between Onset and Death
P.O. BOX 6 hat the death certifi	signed by the attending physic be detached for use as the bu	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditio	1 ☐ Live 4 ☐ Preg 9 ☐ Unk		il death 3□ leath 5□	Ectopic pregnan Other (specify)		23e. Did		3d. Date of deliv Month	ery Day Year he cause of death?
or age	should t								. 1 🗆	Yes 2	No 3∏Prol	oably 4 DUnknown
The la	ate has page 2	Completed							perl	s an opsy ormed? 2 No	24b. Were auto prior to co death? 1 ☐ Yes	opsy findings available mpletion of cause of
ا بِي ا	a this	tlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investig	28a. Date (Mo.	-	ER/Outpatien 28b. Time of Injury	28c. Inj W	ther: 4 🗆 Nursing	eath (Check only Home 5 \(\text{Res} \) 28d. Describe	idence 6		(y)
DIVISION To the Hospital or Attending I	al Director: ed in by the	Certification:	2 Accident Investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Plac	e of Injury - At ho ding, etc. (Specif	ome, farm, stre y)			28f. Location City or To	(Street and own, State)	Number or Run	al Route Number,
ne Hospi 124 hour	To tha Funaral Dir completely filled in	edical		Physician: To the Examiner: On the and mai								
To the within	To I	Me	29b. Signature and title of certifier	ulker	Car)		29c. Licer	nse number 46	285	29d. Date	signed (Month,	Day, Year)
2			30. Name and address of person v	who completed cau				206 For	rt Wassh	ineta	n, Mid. 1	20744
	Sta Registr		31. Date filed (Month, Day, Year)	32	Registrar's Signa							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** Eugene Charles Miller 2007 AUG 26 7:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St Agnes Hospita Baltimore Date of Birth (Month, Day, Year) If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 557-32-1804 1 ☑ M 2 □ F 76 Director Sept. California Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits Director Maryland 1 ☐ Yes 2 X No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be USA 715 Maiden Choice Lane CR101 Funeral 21228 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. d 2 should be filed within 72 hours after of and Mental Hygiene.
7 is marked other than "natural", or iter traumatic event, the Medical Examiner 1 Yes 2 No If Yes, Give Year or Dates: 1951-52 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: WHite þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Postal Service US Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Antoinette Obergefell Rudolph Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau 1 and 2 s James F. Miller Son 1831 Cromwood Road; Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 8/30/2007 Glen Burnie, MD 22. Name and Address of FacilitySterling Ashton Schwab Witzke uneral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licens Nankle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): Examiner neumonio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due t (or as a consequence of) Empyema

Due to (or as a consequence of) signed by the attending physician and defached for use as the burial-tran Physician/Medical renal IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ş tailure 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown congestive Completed disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? diabetes mellitu 1∐ Yes Division or Vital 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 Nnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident or Attend after death Director; completely filled in by the 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital 29a. Certifier 1 - Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 24 To the F 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 2007 D58571 5+1

Registrar DHMH 17 Rev 1/2001

State

Lynn

31. Date filed (Month, Day, Year)

Tao

AUG 2 9 2007

CALL

Avenue

manland

Baltimore

21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900

Caton

32. Registrar's Signature

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lease	Type of I fille in Di	ack machbic mik.	Ellouic / til	00p.00 0
	State of Maryland	Department of He	ealth and Me	ntal Hygiene

Algboshana Ovic	1	- For State Registrar		ate of Death	Reg	No.	1 2761
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last)	ria B	vienriaKhi	2. Date of Death Month D August 26, 2	av Year	3. Time of Death 1931 hrs
(Examin		4a. Facility Name (if not institution, give stree		4b. City, Town, or Location of De Randallstown		4c. County of Death Baltimore Cour	ntv
Europal		Northwest Hospital 5. Social Security Number 6. Sex	7. Age (In yrs. last bir		Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Birth	
Funeral Director	Į	2/6 - 75 - 2268 1 MM 2	1		Min. April 2	Foreign	ntry) Mdr
Maryland 28a-f show any d at once.		10a. State 10b. County Pack w	ince 10c. City, Town	ex Location and all Ato	m		1 Od. Inside City Limits 1 Yes 2 No
death with the Maryland or items 23a or 28a-f shomust be notified at once.	Dire	10e. Street and Number 4142 Brown	Bark Ct	10f. Zip Code	3	Citizen of What Coun	1
after death with or items 2	by Funeral		es'	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 Yes 2 No specify:	erto Rican, etc.)	14. Race - Americ White, etc. Specify:	lack
0036 within 72 hours after giene. rer than "natural", . Medical Examiner.	Completed b	15. Decedent's Education (Specify only high Elementary/Secondary (0-12)	est grade completed) 16a. ollege (1-4 or 5+)	Decedent's Usual Occupation (Give kind during most of working life. DO NOT use The faut		6b. Kind of Business/Ir	ndustry
215- be filed ntal Hyg rked off	Be Com	17. Father's Name (First, Middle, Last) 0606 OV(20)	rakhi	18.Mother's N	ame (First, Middle, Ma	100	Rev
D 21 should, and Mei 7 is mai	٩	19a. Informant's Name/Relationship (Type, P	1 1	b. Mailing Address (Street and Number +142 BRown Bau		2 . 11.4	21/33 M, md.
more, MD Pages and 2 sh tent of Heafth and ant: If item 27 is or other trainmat		20a. Method of Disposition 1 Burial 2 Cremation 3 Re	20b. Place crema	of Disposition (Name of cemetery, tory or other place)	Date	20c. Location - City or	
Baltimore permit. Pages I Department of I Important: If injury or other		4 Donation 5 Other Specify: 21. Sign are of Funeral Se vice 1 c see	- Ilai	22. Name and Address of Facility		HICTOR F	Pass
	- 3	23a Par Inter the disease or complication	ns that caused the death. Do n	ot enter the model of dying, such as card	ac or respiratory arres	e thre four	Approximate Interval
Physician /Mccical	9 4	fallu e. List only one cause on each line	i.	ematurity with viral syn			Between Onset and Death
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	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	(or as a consequence of):				
ecuted and transit	Examiner	(Disease or injury that initiated C.	(or as a consequence of):				
760, cate be exec physician ar the burial - tr	Medical	X UNPENDED AM	Sa,27,perm,EG871.	9/26/07 TT			
Division of Vital Records, P.O. Box 68760, within 24 hours after death, certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	/sician/Me	23b. Was decedent pregnant in the past 12 months?	Pregnant at time of death	2 Fetal death 3 Ectopic pr 5 Other (Specify)	egnancy	23d. Date of delivery Month)ay Year
D. Bc tr the dez by the z	Ph.	Part II. Other significant conditions contri	Unknown buting to death but not resulting	ng in the underlying cause given in Part I		pacco use contribute to	
s, P.O. uires that to n signed by d be detac	ed by	·			1 Yes	2 No 3 Prob	topsy findings available
cords, law requir has been s	Completed				autops perform	y prior to o ned? death?	completion of cause of
of Vital Recoing Physician: The law After this certificate has functal director, page 2 si		25. Was case referred to medical		26.Place of Death (Ch	1 ✓ Yes 2 neck only one)	No 1 ✓ Ye	es 2 No
Vita hysiclan this cer	o Be	examiner? 1 ✓ Yes 2 No	1 Inpatient 2 V Live			Residence 6 Other	
Division of Vital Records, is after dear requirer and reference of the law requirer and reference of the remaining Physician: The law requirement of the remaining the page 2 should be in by the funeral director, page 2 should be	ation: T	1 X Natural 5 Pending 2 Accident Investigation	(Month, Day,Year)	Time of Injury 28c. Injury at Work?		ow injury occurred	and Doube Manches City
Divisior To the Hospital or Attend within 24 hours after To the Funeral Director: completely filled in by the	Certification:	Suicide Suicide Gould not be determined	(Specify)	farm, street, factory, office building, etc.	or Town, St	ate)	ral Route Number, City
Di To the Hospital within 24 hours To the Funcral	Medical	one) 2 Medical Examiner: On the	o the best of my knowledge, do ne basis of examination and/or manner stated.	eath occurred at the time, date and place investigation, in my opinion, death occur	, and due to the cause red at the time, date a	e(s) and manner as statend place, and due to the	e cause(s)
of Williams	Me	29b. Signature and title of certifier	- Pallet	29c. License number O.C.M.E.		29d. Date signed (Mo August 27, 2007	
on or		30. Name and address of person who comple Patricia Aronica-Pollak MD.	eted cause of death (Item 23a) Assistant Medical Exa		more, MD 21201		
S	ate	31. Date filed (Month, Day, Year)	Registrar's Signature	1			
Regis		AUG 2 9 2007	Steern B.	RIGINAL			
DESIGNED IN LICENTIA			U	71 W 11 17 100			

			For State of Ma State of Ma Registrar		artment of Health and N Artificate of Death	_	iene eg. No./ () () / / / / / / / / / / / / / / / /
	Physicia	m	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year
	/Medic	al .	Sunnie J. 4a. Facility Name (If not institution, give street and number)		Pointer 4b. City, Town, or Location of Death	August	26 2007 9:15a. M
	Examin	er	Joseph Richey Hospice	Inc	Baltimore		
i	Funeral Director		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday) 68 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 03 18	Year) 9. Birthplace (State or Foreign Country) VA
	ъ		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	10			ltimore		1X Yes 2 No
	r 28a-	Director	MD NA 10e. Street and Number	DQ.	10f. Zip Code	10	0g. Citizen of What Country?
	th with		2211 Presbury Street		21216		U.S.A.
	er dea tems	Funera	11. Marital Status 12. Was Decedent E Armed Forces?		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc.
2	irs after	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates:		1 ☐ Yes 🎾 No Specify:		Specify: Black
5	72 hou natura ical E		15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation kind of work done during most of worl DO NOT use retired)	king	16b. Kind of Business/Industry John Hopkins
7	ithin 7 ne. han "i e Med	Completed	Elementary/Secondary (0-12) College (1-4or 5	+)			
7	filed w Hygiel ther ti	e Co	10th grade na 17. Father's Name (First, Middle, Last)	S	upervisor 18. Mother's Nam		Hospital Maiden Surname)
2	ld be lental ked o	o Be	Zack Pointer		Geiena	Brando	n
a y	2 shou and M is mar aumat		19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street and Number or Ru	ral Route Number	r, City or Town, State, Zip Code)
,, E	and 2 lealth m 27 i		Luebell Pointer-Wife	2211 20b. Place of Dispo	Presbury Stre	et, Bal	timore, Md 21216 20c. Location - City or Town, State
2	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State	Greater	Brandon (,
Dallilli	artmer artmer ortant Injury		4 □ Donation 5 □ Other (Specify) 21 Stantature of Funeral Service Ligensee	Chapel	Church 9/1 2. Name and Address of Facility arch F/H West	/ U / A	lton, VA
0	permit. Departr Importa any Inji		> Xerraid V. Qual		arch F/H West 300 Wabash Ave	, Balti	more, Md 21215
1	100		23a. Par 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not ent	ter the mode of dying, such as cardiac	or respiratory arre	est, Approximate Interval Between Onset and Death
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XO	death certifi e attending id for use as		IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant		⊒Ectopic pregnancy		23d. Date of delivery
Š	w requires that the death certif been signed by the attending should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at		Other (specify)		Month Day Year
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cords	law req as been 2 shou	lete				24a. Was a	
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VITA	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner.			ath (Check only or	Harlan
20	s ∞ =	ဥ	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatie 27. Man, er of Death 28a. Date of Inju			fome 5 ☐ Resid	lence 6 Dother (Specify) 104/16 P
Sion	ng Mftel	tion	1 Natural 5 □ Pending (Month, Da 2 □ Accident investigation	y Year) Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		
NSI N	Attendier death.	Certification:	3 Suicide 6 Could not be 28e. Place of inj	ury - At home, farm, st c. (Specify)	treet, factory, office	28f. Location (S City or Tow	Street and Number or Rural Route Number, rn, State)
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	f examination and/or in	nvestigation, in my opinion, death occ	urred at the time,	date and place, and due to the cause(s)
	To the within To the Complete Complete To the	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Month, Day, Year)
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/	5		30. Name and address of person who completed cause of	feath (Item 23a) (Type	7 V. Lolae tore	R. 1+	ang 26, 8007
	Sta		31. Date filed (Month, Day, Year) 32. Registr	rar's Signature	beste	, 1/0/	17/1/2/
	Regist	rar	HUU GO LOUI JENES				

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Phy Medical Ex	ysicia xamir		Decedent's Name (First, Middle Lonnic	le,Last) Lonnie Theo	lore Pay	ne Pay	me_			Date of Death Month E August 18, 2	Day Year 2007	3. Time of Death 1940 hrs
			4a. Facility Name (if not institution St. Agnes Hospital	n, give street and number)		4t	. City, Town, or Baltimore	Location of	f Death		4c. County of	
Fund			5. Social Security Number		In yrs. last birl	thday)	If Under 1 Year		r 24Hrs. 8	. Date of Birth	(MM/DD/YYYY)	9. Birthplace (State or Foreign
Direc	ctor	_ L	219-80-3047 Usual Residence of Decedent	1 X M 2 F	46	Yrs.				12-24-	1960	Country) Md.
C.	ow any		Md. NA		c. City, Town				-14	- 17	:	10d. Inside City Limits 1 X Yes 2 No
Aarylano	28a-f show d at once.	Director	10e. Street and Number	3		Baltin	10f. Zip Code		e s	. 10g	. Citizen of Wha	at Country?
th the N	rifie		2627 Hafer Str				21223				USA	Plant Plant
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene.	, or items 23a or 28a-f shor must be notified at once.	Funeral	^	arried 12. Was Decedent Example 12. Was Decede	Forces? If Yes, specify Cuban, Mexican, Puerto					fy Yes or No- an, etc.)	14. Race - White, Specif B 1	
ours after	amine.	a P	15. Decedent's Education (Spe	or Dates:	eted) 16a.	Decedent'	s Usual Occupa	tion (Give k	kind of work		6b. Kind of Bus	
0036 vithin 72 ho	t: If item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner must be	Completed	Elementary/Secondary (0-12) 11th grade	NA			st of working life				NA	
ore, MD 21215-C	ked oth	Be Co	17. Father's Name (First, Middle, Lonnie	Theodore	Pay	me, S	Sr.	18.Mother's	*. "	rst, Middle, Ma	iden Surname) MC	Bride
D 21 should I	27 is mar		19a. Informant's Name/Relations Juanita Brown	,	19	•	Address (Stre					, State, Zip Code)
e, M I and 2 Health	If item 2 her traui	1	20a. Method of Disposition				on (Name of ce					City or Town, State
Baltimore, MD permit. Pages I and 2 sho Department of Health and	tant: 1		4 Donation 5 Other S			Carı	nel Cer		8-29	9-07	Dunda	lk, Md.
Baltimo permit. Pag Department	Importing		21. Signature of Funeral Service	Licensee	ر د		me and Addres		. Ma	arch F. Balti	H. East more, M	d. 21202
Physic			23a. Part I. Enter the disease, or failure. List only one cause	complications that caused the on each line.	e death. Do n	ot enter the	mode of dying	, such as ca	ardiac of re	spiratory arres	t, shock, or hea	Approximate Interval Between Onset and Death
Exami		1	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence)			_					Death
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, / p	d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a consequent	uence of):							
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8760 iificate b	ng physi is the bu	n/Me	IF FEMALE: 23b. Was decedent pregnant in the		a. pg,	-	al death 3		pregnancy	y	23d. Date of o	delivery Day Year
sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be reath.	the attending physician and the for use as the burial - tra	Physician/Medical	past 12 months? 1 Yes 2 No 9 Un	4 Pregnant at tir			er (Specify)					
P.O. I	gned by detach	Š	Part II. Other significant condit	tions contributing to death b	out not resultin	ng in the ur	derlying cause	given in Pa	irt I.			oute to the cause of death? Probably 4 Unknown
rds,	been sig	leted					•		_	24a. Was ar	1 24b. W	Vere autopsy findings available
of Vital Records, P.O. g Physician: The law requires that th	icate has page 2 s	Completed								perform 1 V Yes 2		eath? Yes 2 No
/ital	is certif director,	o Be (25. Was case referred to medica examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 ER/C	Outpatient	26.Plac 3 ✔ DOA	e of Death Other	(Check only Nursing F		tesidence 6	Other:
of \	After th	-1	27. Manner of Death	28a. Date of Injury (Month, Day,Yea	28b.	Time of In		ury at Work		d. Describe ho	ow injury occurre	ed
Division tal or Attendir	ector: by the	icatic	2 Accident Inve	stigation FIR O/ 10/ 4		d 7:00	DIII	Yes 2 X		unk sf. Location (St	reet and Numbe	r or Rural Route Number, City
Div pital or	filled in	Certification:	4 Homicide	Id not be (Specify) St. I						or Town, Sta altimore	, MD	
Divi	the Fun npletely	Medical (29a. Certifier (Check only one) 2 Medical Exa	hysician: To the best of my laminer: On the basis of exami	knowledge, de nation and/or	ath occurr investigation	ed at the time, on, in my opinio	late and pla n, death oc	ace, and du curred at th	e to the cause ne time, date ar	(s) and manner nd place, and du	as stated. ue to the cause(s)
To To	To	Mec	29b. Signature and title of certific	and manner stated.				se number	OCME	T		ed (Month, Day, Year)
	,		Throday &	1, Kg JR,	ith (Item 23a)		0.C	.M.E.			August 19,	ZUU <i>1</i>
10			 Name and address of persor Theodore M. King, Jr. 	4/		niner	111 Penn S	treet, Ba	ltimore,	MD 21201		
R	Sta Regist		31. Date filed (Month, Day, Year)	A 7	Signature	SHE						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Elaine Marie Quickley 12:35p^N /Medical 23 2007 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore 236 St. Matthews Street NA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours 1 ☐ M 2 🛣 Director 212-36-4535 68 6-4-1939 Md. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 No Director Md. Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 236 St. Matthews St. 21202 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: à 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: if item 27 is marked other the any injury or other traumatic event, ite. Once. <u>Housekeeping</u> 12th grade J.H.H 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Washington George Lipscomb Mary Ouicklev 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1303 Queens Puchase Rd., Essex, Md.
Disposition (Name of Date 20c. Location - City or Town, State <u>Janet Brandon</u> Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) Mt. Zion Cem. 8-29-07 Lansdowne, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 21202 lad 1101 E. North Md. Ave., Baltimore, Wanes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PANCREATIC CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Day to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the burial Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No page 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 \(\sum \) Nursing Home 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Presidence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of I Director: After to d in by the funera Certification: Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

amphisous

31. Date filed (Month, Day,

·VERGARA-SOARES

Year)

MO

9940

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANKLIN

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SQUARE

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August 28 2007

BACTIMORE MP 2/236

	Sta Registra	te	31. Date filed (Month, Day, Year)			ire		DOLL	LINT	C, FID	te de la la la				
	20		30. Name and address of person will K.S. Dharmasena,					Ral+	imor	e Min	2122	5			
)	Z × Z		29b. Signature and title of certifier	umageus,	ww	,		7753	iaiiiDel				signed (Mor -2007	itn, Daj	y, Tear)
	thin 24 h	Medical	(Check only 2 Medical Ex	kaminer: On the basis of and manner sta	examinati	on and/or inv	vestigation,	in my opi	nion, deat	h occurred	at the time,	date and p	place, and du	ue to th	e cause(s)
ā			29a. Certifier 1 XZertifying	Physician: To the best of	of my know	/ledge, death	1 occurred a	t the time	e, date and	d place, and	City or Tow	cause(s) a	and manner:	as state	ed.
visio	Attendi er death. ector: A by the fu	Certification:	2 Accident investigat 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of inju	ıry - At hor	ne, farm, stre	М	1 □ Y	es 2∐N	-	Location (S	Street and	Number or F	Rural R	oute Number,
Division or Vital Records,	ding Physician: The In. After this certificate he funeral director, page	on: To	1 ☐ Yes 2X ☐ No 27. Manner of Death 11 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	ry	R/Outpatien 28b. Time of Injury		c. Injury a	4 LAI Nurs		5 Resid			ecify)	
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ords	w requires been sign should be	eted by	Intestinal Angi	.odysplasia					-	_	1 🗆 '	Yes 2□]No 3□F	Probab	ly 4 XUnknown
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	The law requires that the death certificate has been signed by the attending ploage 2 should be detached for use as to	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3□	Ectopic pre					23	3d. Date of d Month	elivery Da	ay Year
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nd 2	be filed Ital Hygi of other event, tl	Be	17. Father's Name (First, Middle, L.	· ·	ı	nomema	IVET			,	First, Middle,	Own I Maiden S			
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	ath with 23a or ust be r	ral Dir	2830 Vermont Ave	e.			212					USA	en or what c	Jountry	
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Water of	/Medic Examin	cal	Rose Mary Rohled 4a. Facility Name (If not institution,				4b. City, 1	Fown, or I	ocation of		08/11/	2007	County of De	1	2:15 PM
3	Physici	an	1. Decedent's Name (First, Middle,	,			imoure			2	2. Date of De	Reg. No.	Yea		3. Time of Death
			For State Registrar	State of Ma	aryian		arımeni <i>rtificate</i>			ina Me		/	200	7	07670

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Las 2. Date of Death 3. Time of Death Day 4b. City, Town, or Location of Death Name (If not institution, give 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 1 12 M 2 □ F Hours Min SEPTEMBER 2,1931 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No ANNE ARUNDEL BROOKLYN 10e. Street and Number 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) USA 14. Race - American Indian, Black, White, etc. AVENUE 12. Was Decedent Ever in U.S. Armed Forces? 1 17 es 2 □ No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WESTINGHOUSE /2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LEOPOLD GERTRUDE FISCHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLEN BURNIE 19a. Informant's Name/Relationship (Type. Print) PATRICIA MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 127/07 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE BAYVIEW CREMATORY 22. Name and Address of Facility GONCE 21. Signature of Funeral Service Licensee FUNERAL SERVICE P.A. RITCHIE HWY BALTO. 23a. Part1. Enter the disease or complications that caused the shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death)

Physician /Medical Examiner

physician and the burial-transit

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Completed

To Be

Certification:

Medical

Division or Vital Records,

To the Hospital or Attending

within 24 hours after death To the Funeral Director:

Physician /Medical

Examiner

10a. State

Funeral

Director

items 23a or 28a-f show ner must be notified at

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Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any Injury or other traumatic event, the Medical is

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Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner

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that initiated events resulting in death) Last	
IF FEMALE: 23b. Was decedent pregr	ant

in the past 12 months?

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

autopsy perfori

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

25. Was case referred to medical examiner? Hospital: 1 ☐ Yes 2 No 1 Inpatient

determined

26. Place of Death (Check only one) Other: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

28a. Date of Injury 27. Manner of Death 5 Pending investigation **N**atural 2 Accident 6 ☐ Could not be 3 ☐ Suicide

28b. Time of (Month, Day Year)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

9

AUG 2

29c. License number

29d. Date signed (Month, Day, Year)

cause of death (Item 23a) (Type, Print

Hanover

State Registrar

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and I	Mental Hygier	ne G G T	07/00		
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1	/Medid Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	-	c. County of Death	7. 70		
			Northwest Hospital Center Randallstown	1	Baltimor	C		
	Funeral		5. Social Security Number 6. Sex 1 M 2 F Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Whin.	8. Date of Birth (Month, Day, Yea	9. Birtho Coun	ace (State or Foreign try)		
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Maryland 21215-0036	0 40 70 90		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru					
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	/Medical Examiner		resulting in death) July to (or as a consequence of):	1				
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s,	9 <u>5</u> 9	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		use contribute to th			
Örd	v requir	eted		1	2 Mo 3 ☐ Proba	ably 4 Dunknown		
Rec	hast pe2s	Completed		24a. Was an autopsy performed?	prior to con	sy findings available apletion of cause of		
	sicien: The certificate rector, pag	င္ပ	25. Was case referred to medical / 26 Place of Dea	1 ☐ Yes 2 ☑/N		2□ No		
Division of Vital Records,	Physicie this cert al direct	ToB	examiner? Hospital: Other	ome 5 Residence	6 ☐Other (Specify)		
0	ding Ph h. After th funeral		27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work?	28d. Describe how in				
sio	ttendi death. ctor: A / the fu	catl	2 Accident investigation M 1 Yes 2 No					
<u>∑</u>	l or Atten after deatl Director: in by the	Certification:	4 Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street : City or Town, Sta		Route Number,		
_	spite nours nerel	a C	29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place,	and due to the cause	s) and manner as sta	ited.		
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate h completely filled in by the funeral director, page	edical	(Check only 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	red at the time, date a	nd place, and due to	the cause(s)		
)	To T	Σ	29b. Signature and title of certifier 29c. License number	29d. D	ate signed (Month, L	ay, Year)		
,	10		the sunney 11/5/6	fo Hu	gust 22	2007		
_	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print). Ian Sunshine, MD 6210 Park Heights Awe, Bo	Utimore W	1D 21215			
		State 31. Date filed (Month, Day, Year) 32. Registrar's Signature						
	Registr	ar	AUG 2 9 2007					

07-0 Dav

ck Indelible Ink Ensure All Copies Are Legible

07-06635 David Santiago	State of Maryland / Department of Health a	and Mental Hygiene
	1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last)	Reg. No. 2. Date of Death 3. Time of Death
Physician/	David Saniago David Santiago	Month Day Year 0026 hrs August 27, 2007
		, or Location of Death 4c. County of Death
·	7009 Arundel Mills Boulevard Hanover	Anne Arundel Vear Lift Index 24Hrs
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Y Months 581–15–0038 7rs.	Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) NY
· · · · · · · · · · · · · · · · · · ·	Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location	10d. Inside City Limits
ow any	10a. State 10b. County 10c. City, Town or Location 10c. Ci	1 Yes 2 X No
ne Maryland or 28a-f show fred at once.	10e. Street and Number . 10f. Zip Cod	de 10g. Citizen of What Country?
he Marylan 1 or 28a-f st iffed at onc	7552 Wigley Ave. 20794	USA
- 2 =		f Hispanic Origin? (Specify Yes or No- uban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
death with	1 Never Married 2 XMarried Armed Forces? If Yes, specify CL	
	or Dates: 1980-95	No specify: Puerto Rican Specify: Hispanic supation (Give kind of work done 16b. Kind of Business/Industry
hours Fram		glife. DO NOT use retired)
36 iin 72 e. than "	Police Office	
Baltimore, MD 21215-0036 pernit. Pages 1 and 2 shouldbe filed within 72 hours after Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "naturell", injury or other traumatic eyent, the Medical Examples.	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, Maiden Surname)
215 be file mtal H rked ent, t	Efrain Santiago	Juana. Pena Street and Number or Rural Route Number, City or Town, State, Zip Code)
hould hould is ma	Tod: Midmidal Company	Ave., Jessup, MD 20794
MD and 2 sho and 2 sho sm 27 is raumati	20b. Place of Disposition (Name of	
OTE,	1 X Burial 2 Cremation 3 Removal from State crematory or other place)	
Baltimore, pernit. Pages I at Department of Hes Important: If the	1 4 Donation 5 Other Specify:	
Ball permi Depar Impo	21 Organization of Funeral Service Licensee Mo1378 7250 Was	Kaufman Funeral Home at MMP, INC. hington Blvd., Elkridge, MD 21075
Physician	23a Part I. Enter the disease, of complications that caused the death. Do not enter the mode of diffailure. List only one cause on each line.	lying, such as cardiac or respiratory arrest, shock, or heart Between Onset and
Medical	Immediate Cause (Final disease a. Oxycodone intoxication	Death
aminer	or condition resulting in death) Due to (or as a consequence of):	
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
nsit	Course Fnier Underlying Cause (Disease or injury that initiated	
it of di	events resulting in death) Last Due to (or as a consequence of):	
	ŭ	9/7/07 Tt
		23d. Date of delivery
on of Vital Records, P.O. Box 68760, ending Physiciam: The law requires that the death certificate be sath. or: After this certificate has been signed by the attending physici the funeral director, page 2 should be detached for use as the built in the funeral director, page 2 should be detached for use as the built in the funeral director.	23b. Was decedent pregnant in the 1 Live birth 2 Fetal death	3 Ectopic pregnancy Month Day Year
OX 6	past 12 months: 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown	x)
that the de detached by the	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying ca	ause given in Part I. 23e. Did tobacco use contribute to the cause of death?
rds, P.O. requires that the been signed by should be detach		1 Yes 2 No 3 Probably 4 ✔ Unknown
ords, ** requir s been s should!	ool de la company de la compan	24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
e law e has e has	<u> </u>	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
USST of Vital Recing Physician: The After this certificate Innertal director, page	25. Was case referred to medical 26	.Place of Death (Check only one)
Vital vsician: his certifi	examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DO	
MS rof V ling Phys	. 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28	ic. Injury at Work? 1 Yes 2 X No 1 Imk
ion ttendi death.	Natural 5 Pending Investigation Fnd 8/27/2007 Fnd 12:23 am	
Division Division Inspiral or Attendi I hours after death. Inneral Director: A	1 Natural 5 Pending Investigation 2 Accident Investigation 3 X suicide 4 Homicide Could not be determined (Specify) Scene (Month, Day, Year) Fnd 8/27/2007 Fnd 12:23 am 28e. Place of Injury - At home, farm, street, factory, or (Specify) Scene	or Town, State) 7009Arundel Mills blvd. Hanover MD
2 2 2 3	1 298. Certifier	ime, date and place, and due to the cause(s) and manner as stated.
Div To the Hospital or within 24 hours afty To the Funeral Div	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my control of the basis of examination and/or investigation, in my control of the basis of examination and/or investigation.	opinion, death occurred at the time, date and place, and due to the cause(s)
To t with To t	and manner stated.	License number 29d. Date signed (Month, Day, Year)
		O.C.M.E. August 27, 2007
	30. Name and address of person who completed cause of death (Item 23a)	ND 01001
est.	Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Per	nn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

State 31. Date filed (Month, Day, Year)
Registrar AUG 2 9 2007

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 8130 AM 27,000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA McKewin If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours Min. 219-01-346 1**⊠**M 2□F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☑Yes 2 ☐ No Director ma, 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mckew 0 Be Completed by Funeral 12. Was Décedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 Neyer Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 Widowed 4 □ Divorced Specify: 1946 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STEEL Inspector 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) -daughter Ave. Balto, md. McKewin 623 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 F
4 Donation 3 Other (Specify) 3 □Removal from State 30-07 21. Signature of Juneral Service Ligensee 22. Name and Address of Facility Z Fred HILTON Manual Court of March Reveal the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, (Cital). there Balto. 23a. P. rt1. E. ter ne s sh k, or h art fail Immediate car se (Final disease or condition resulting in death) Approximate Interval Between Onset and Death **Physician** /Medical Due t (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence or, been signed by the attending physician and should be detached for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform After this certificate 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Natural 5 ☐ Pending investigation 1 ☐ Yes 2 🗌 No after death 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, AUG 29

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29c License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dyr e870 8-29-07 yr State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 9:21 AM Willie J. Springs Aug 24 ,2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death EVINDALE BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 1 M 2 □ F Months Days Hours Min. 213-32-1482 11-5-1933 S.C Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4907 Goodnow Rd. Apt. E 21206 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 ☐ If Yes, Give Year or Dates: 2 □ No 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 17. Father's Name (First, Middle, Last) yrs. Military Navy 18. Mother's Name (First, Middle, Maiden Surname) Hillard Wilkes Mary Springs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21206 19a. Informant's Name/Relationship (Type. Print) Elouise Springs Wife 4907 Goodnow Rd., Apt. E., Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Nat. Cem.8-31-07 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1101 E. North Ave., Baltimore, Md.21202 Warre 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CORDNARY ARTERY DISEASE disease or condition resulting in death) Due to (or as a consequence of): FAILURE RESPIRATORY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): FAILURE RENAL Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? BRAIN INJURI 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 X/No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation

Physician /Medical **Examiner**

Examine

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

ortant: If Item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be in

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "in any injury or other trainment.

within 72 hours after

Maryland 21215-0036

Baltimore,

Director

Funeral

2

Completed

Be

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Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Division or Vital Records, P.O. Box 68760 physician the as attending for use ed by the a detached f been signed be should be deta page 2 should

Physician/Medical þ Completed Be

1 Natural 2 ☐ Accident

3 Suicide

29a. Certifler

4 Homicide

(Check only one)

29b. Signature and title of certifier

certificate has director, ပို this After t Certification: Medical

the

٥

State Registrar

6 Could not be determined

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

D0062733 phiram of WOLDERHINUT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gizaw Wolderiwot 2434 W. Belvedere Ave. Baltimore, Md. 21215

and manner stated

31. Date filed (Month, Day, Year)



Injury

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2300 DULANEY VALLEY ROAD

TIMONIUM, MD 21093

State Registrar

AUGUST

MILDRED

M.D.

32. Registrar's Stonature

ERNESTINE WRIGHT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amend Item 8 per fh, g878 O4/08/08dhb

Beg No.

Beg No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day ELIZABETH SPEAR 2007 2:15 A M 28 August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death

Balfimore Examiner 4b. City, Town, or Location of Death St Joseph Medical 10WSOM If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 06/10/1918 89 Director 187.03.4772 PA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at Director MD Baltimore Towson 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 22 any injury or other traumatic event. The Natural of them 2000. by Funeral U.S.A.
14. Race - American Indian, 531 Stevenson Lane 21286 Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Neyer Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 ₩idowed 4 Divorced Specify: U.S.A. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Radio-Radar 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George A. Jones Marie Hummel ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel P. Spear/son 15 <u> Jacana Street, Hilton Head, SC 29928</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 08.31.07 | Beltsville, MD MOILY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation And Funeral Balto Alternatives 8717 Green Pastures Dr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Oaset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Vementia **Physician** ears. /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Severe Osteo porosi) with fracture of femus 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed Stata, port Operative Reduction and Internal Fixation 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 24 hours after death. 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2. 29b. Signature and title of certification 29c. License number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marc I. Leavey WD 1205 York Road #38 Lutherville WD)

Registrar's Sign

. 17041

29d. Date signed (Month, Day, Year)
28 August 2007

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar		rtificate of I			Reg. N		
۲		Si	Decedent's Name (First, Middle, Last)				2. Date of De		LU	3. Time of Death
	Physicia /Medic		Catherine E. Skweres				ANGVET	- 2	+ 2-00	7 12.45AM
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	0 -	4	c. County of Dea	th 0.3
3.4			5. Social Security Number 6. Sex 7. Age (In yrs. las	AP et hirthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	ANHE	THUNDEL thplace (State or Foreign
	Funeral Director		216-03-3364 1		Months Days	Hours Min.	07/20	/19	16	ountry) MD
	/land ow			Town or Lo	ocation					10d. Inside City Limits
	a-f sh	ctor	MD Anne Arundel Pa	sade	na					1 ☐ Yes 2 No
	or 28.)ire	10e. Street and Number		10f. Zip Code			10g. C	itizen of What Co	ountry?
	ath wi	ral	301 Magothy Bridge Road		21122				.S.A.	
	er de	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 M Married 1 □ Yes 2 M No	. 13. '	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, Whi	
0000	urs aft	by F	1 ☐ Never Married 2 🛣 Married 1 ☐ Yes 2 🖼 No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:			Specify: W	hite
5	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	ation	dina	16b. I	Kind of Business	/Industry
V	ithin ne.	mple	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done o DO NOT use retired)	ung			
7	Hygie Hygie ther ti nt, th	Š	1 2 17. Father's Name (<i>First, Middle, Last</i>)	Hoi	memaker	18. Mother's Nam	e /Firet Middle		n Home	
מב	ould be f Mental f arked of atic eve	Be c	Gordon Plummer Lowman			Berty	·		n Sumame)	
<u></u>	2 should and Men is marker aumatic	2	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a				or Town, State,	Zip Code)
M	alth al 27 is 27 is		Raymond Skweres/Husband							a, MD 21122
บั	of Health of Fitem 27 is		20a. Method of Disposition 20b. Pla	ce of Dispo	sition (Name of matory or other place	i	Date		ocation - City or	
Ĭ	Pages ment of I ant: If its ury or o		1	n Hav	ven Mem	Pk 08/2	27/07	G1	en Buri	nie, MD
	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee	16	2. Name and Addres	era Driv	J.Gono	ce :	Funeral	Home, PA
			23a. Part1. Enter the risease, or complications that caused the death. shock, or heart ailure. List only one care on each line.							Approximate Interval Between
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	/Medical Examiner		resulting in death)							10000
	Examiner	er	Sequentially list conditions, if any leading to immediate	naa afii						PAR
	rted nsit	nlne	cause. Enter Underlying Cause (Disease or injury that initiated events	rice off:						
	execu n and ial-tra	Examine	that initiated events resulting in death) Last c Due to (or as a conseque	nce of):						
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5	rtifica ng ph	Med	IF FEMALE:					I		
5	ath ce ttendi or use	ian/I	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pr pregnant 1 □ Live birth 2 □ Fetal d	leath 3□	Ectopic pregnancy				23d. Date of de Month	livery Day Year
5	the de	Physician/	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of dea 9 ☐ Unknown	ıth 5∟	Other (specify)				Month	Day 10ai
	that ned by detail		Part II. Other significant conditions contributing to death but not resulti	ing in the u	nderlying cause give	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
S C	quires an sign uld be	ed by			· · · · · · · · · · · · · · · · · · ·		10	Yes 2	2 □ No 3 □ P	robably 4 Inknown
כ כ	law re	Completed					24a. Was		24b. Were a	utopsy findings available
	The ate ha	E O			,		auto perfo 1⊟ Yes	ormed? 2 N	death?	completion of cause of ; 2 ☐ No
2	cian: ertific ector,	Be	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only	one)		
5	Physi this c al dire	은,		R/Outpatien	othe	4 🗀 Nursing H			6 □Other (Spe	ecify)
5	ding h. After funer	tion	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Injury	Worl	γαι (? Yes 2∐No	28d. Describe	now inji	ary occurred	
200	Atten er deat ector: by the	Certification:	3 ☐ Sulcide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined 28e. Place of injury - At hom building, etc. (Specify)	e, farm, str			28f. Location (City or To	Street a	and Number or R	ural Route Number,
2	ital or irs afte ral Dir lled in	Cert								11
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge of the desired physician of the basis of examination and manner stated.	edge, death n and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	and due to the rred at the time	cause(, date a	s) and manner a nd place, and du	s stated. e to the cause(s)
	To th Within To th	Me	29b. Signature and title of certifier		29c. License	number		20d. D	ate signed (Mon	th, Day, Year)
			(rehap m)		104	र १५५		Cer	rgust	24 2007
	4		30 name and address of person who completed cause of death (Item 2	3a) (Type,		1.40	Glen	· h	urue	mis 2016
	Sta Registra		31. Date filed (Month, Day, Year) 32. Tegistrar's Signatur		. w.			_		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 210 a 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City, Town, or Location of Death Year | If Under 24 9. Birthplace (State or Foreign Country) California If Under 1 8. Date of Birth (Month, Day, May 7, Age (In vrs. last birthday) Year) Months Days Min 12 M 2 F Yrs. 132-36-6074 61 1946 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6012 Burnt Oak Road 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Inventory Manager Automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stanley Shea Violet Cole 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Norma Jean Shea Wife 6012 Burnt Oak Road; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 ☐Removal from State St. John's Cemetery 8/29/2007 Ellicott City, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Suneral Service Licenses Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue: Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TIL Due to (or as a consequent of) Sequentially list conditions, if any leading Land Clause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Date of Injury (Month, Day Year) 2 ER/Outpatient 3 DOA

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

within 72 hours after

d 2 should be filed within 7 h and Mental Hygiene. **7 Is marked other than "**r

permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked of any injury or other traumatic ev

injury or other traumatic event,

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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/Medical

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P.O. Box 68760.

Division or Vital Records,

Examine edical funeral Certification:

To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral

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27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

5 Pending investigation

6 ☐ Could not be

determined

Medical

10	
Sta	ite
Registr	ar

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature Date filed (Month, Day, Year. 9 AUG

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

		1	For State of Ma State Registrar Amend 20b, perFD, g870, 8/29				-	Reg. No.	7 40	27583		
Phys	siciar	_	JEANNE TERBORG				2. Date of De Month AUG. 2	ath Day 200)7 Year	3. Time of Death 12:30P M		
	edica mine		a. Facility Name (If not institution, give street and number)		4b. City, Town, or L				ounty of Death			
Fune Direct		5	SHANGRI-LA ASSISTED LIVING i. Social Security Number 6. Sex 7. Age 1 M 2 F 7. Age 1 M 2 F	e (In yrs. last birthday) 90 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Bir Month, Da 9/15/1	916		lace (State or Foreign		
0		1		10c. City, Town or Lo					1	0d. Inside City Limits		
with the 3a or 28a		5	10e. Street and Number 5484 SLEEPING DOG LANE		10f. Zip Code 210)45		10g. Citize	en of What Cour	ntry?		
Nore, Maryland 21213-90036 ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If Item 271s marked other than "natural"; or items 23a or 28a-f show the training of other than Medical Evaniner mist be notified at	L	by rur	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 1 □ Yes, Give Year, or Dates:	Ever in U.S. 13.1	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 🏋 No	panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		I. Race - Americ Black, White, Specify: BLA	etc.		
Z1Z15-UU36 d within 72 hours af giene. er than "natural", or	Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Give	dent's Usual Occupa kind of work done do DO NOT use retired) INISTRATIV	uring most of work			of Business/In			
and 21		e n	12 1 17. Father's Name (First, Middle, Last) EARL VANHORN	ADM.		18. Mother's Name MABEL	e (First, Middle					
maryland and 2 should be file salth and Mental H n 27 Is marked oth		2 _	19a. pt/cgggris Namorfalatipoship (Typp Print) ROSALYN 'T' PENN Y DAUGHTER	19b. Mailii 5484	ng Address (Street a							
Baltimore, permit. Pages 1 a Department of Hee Important: If Item	is of other		20a. Method of Disposition 1 ☐ Burial 2 [XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		osition (Name of matory or other place REMATORY	8/29/ 8/27	2007 707		ation - City or To			
Baltimo	once.		21. Signature of Funeral Service Licensee	// / - I	2. Name and Address 4600 LIBER		WELL FU			21207 , MD		
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	De C	2	ַ הַ	Part II. Other significant conditions contributing to death by Type II Diabetes Mell		underlying cause give	en in Part I.				the cause of death? bably 4 □Unknown	
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To the Hospital within 24 hours a To the Funeral I	Tpietely	Medical	29a. Certifier (Check only one) 11d Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	of examination and/or i	investigation, in my o	pinion, death occu	irred at the time	e, date and	place, and due	to the cause(s)		
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			1 - For State Registrar	State of Maryla	,	artment of Hertificate of D				27587
			Decedent's Name (First, Middle, Last,			timoato or E		2. Date of Death	g. No.	3. Time of Death
	Physic		Edith R. BI	ackson T	oney			Month	Day Year 28 2007	3:00 PM
	/Medi Examir		4a. Facility Name (If not institution, give			4b. City, Town, or		1/0-10-1	4c. County of Dea	
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	Funeral	4	Social Security Number 6. Security Number	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March	Yearl 9. Bit	rthplace (State or Foreign ountry)
	Director		212-18-3376	10	Yrs.			March ?	7,1906	MD
	land		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Mary	ō	MD NI	A	Bea	ltimore				1 ☐ Yes 2 ☑ No
	the 28a	rec	10e. Street and Number	, 1		10f. Zip Code		10	g. Citizen of What C	ountry?
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	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or Itams 23a or 28a-f show int, the Medical Evandra must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.	Was Decedent of His f Yes, specify Cubar		ecify Yes or No-	14. Race - Am	
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	1 and 2 Health a tem 27 is		Nona D. Diggs/G	Jardian - Niece	29	07 mt.	401/2 S	4 Ast 2	Baltimon	0 MD ZIZ16
Jre,	of Health item 27		20a. Method of Disposition	20b.		sition (Name of natory or other place	, 1		Oc. Location - City or	Town, State
Ē	Pages nent of h ant: If ite ary or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	emovar mom State		M. Cem ete	m 9/6	107	Trapp	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Evantment by notifier at any injury or other traumatic event, the Medical Evantment by notifier at ange.		21. Signature of Funeral Service Licen			. Name and Address	Facility	COEU	never 1 S	MO Centoe, P.A.
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ш			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the dea se cause on each Jim .	th. Do not ent	er the mode of dying	, such as cardiac	or respiratory arres	st,	Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	0				-
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œ.	the att	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of a		Ectopic pregnancy Other (specify)		1	Month	Day Year
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of	Phys this ral dia	: To	1 ☐ Yes 2 ☐ No '' 27. Manner of Death	1 Inpatient 2 28a. Date of Injury	ER/Outpatien 28b. Time of	28c. Injury	4 Mursing Ho	me 5 Residen 28d. Describe hov	ce 6 Other (Spe	ecify)
ou	ding Ph h. After th funeral	tlon	1 ☐Natural 5 ☐ Pending	(Month, Day Year)	Injury	Work	es 2 🗆 No	ZOG. Describe NOV	riquiy occurred	
Division	or Attending after death. Director: After in by tha fune	Certification;	3 Suicide 6 Could not be	28e. Place of Injury - At h	iome, farm, stri			28f. Location (Stre	et and Number or R	ural Route Number.
Ö		erti	4 Homicide	building, etc. (Speci	<i>(y)</i>			City or Town,		
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	in 24 he Fu pletel	edical	(Check only 2 Medical Examir	er: On the basis of examina and manner stated.	ation and/or inv	estigation, in my opi	nion, death occur	ed at the time, dat	e and place, and due	e to the cause(s)
	To the within 2 To the complet	Ň	29b. Signature and title of certifier	_		29c. License			d. Date signed (Mont	
	-		1	mo		1)2	7569		87291	57
5			30. Name and address of person who co	mpleted cause of death (Iter	m 23a) (Type,	Print)	, /-	-	.0	07
/			Allen 21 Date filed (15 - 15 2)	Sett len		1838	GTE	me (f	ee on	0,208
	Sta Registr	-	31. Date filed (Month, Day, Year)	32. Registrar's Signa	A A	Belle D				

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AMEND TTEM/5 18 19a per INF G871 9/10/07 US
State of Maryland Department of Health and Mental Hygiene 1- State Registrar Amend 14,20b, perFH,6870, 8/29/07 TICertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Mary Travis Todd 1555 p 08 22 2007 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Bethesda Maryland Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 1 ☐ M 2 ☐ F 76 07/28/1931 Florence, S. C. Director 10c. City, Town or Location r 28a-f show notified at 10a, State 10b. County 10d. Inside City Limits 1 Yes 2 No Silver Spring, Maryland Director MD Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? a or 5 Hilltop Road 20910 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. .1 and 2 should be filed within 72 hours after thealth and Mental Hygiene. tem 27 is marked other than "natural", or itel wither traumatic event, the Medical Examiner 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ Specify: WHITE 3 ☐ Widowed 4 ☑ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Montgomery College Teacher 18. Mother's Name (First, Middle, Maiden Surname)
Fleety Altman
Fleely Altom 17. Father's Name (First, Middle, Last) To Be <u>Marion C. Todd</u> 9a. Informant's Name/Relationship *(Type. Print)* **Mark Hillmann** Mark Hillman (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traum once. Hilltop Road Silver Spring, Maryland 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 08/24/2008 Washington, D C 4 ☑ Donation 5 ☐ Other (Specify) <u>Howard University</u> 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Licensee <u>B821 14th Street N W. Washington, D C 20011</u> 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one can see on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician METASTATIC BREAST CANCER disease or condition resulting in death) #_WEEKS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine he law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ※ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown <u>Renal Failure</u> Be Completed Electrolyte Disturbance 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has e 2 s autopsy performed? Yes 2 \textbf{\text{No}} Fever 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 XNatural 5 ☐ Pending investigation Injury 1 ∏Yes 2 ∏No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0059244 August 22, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4416 East-West Hwy Ste 410 Bethesda, Maryland 20814 Giselle Mery ∰egistrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 9 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Josephine G. Torosino 1:15 AM 23 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ST. ALNES BALTIMORE HOSPITAL 8. Date of Birth (Month, Day, Year) March 21,1921 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ☐ M 2 🔀 F Months Days Hours Min 86 219-12-8560 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2X No Maryland Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21043 USA 5117 Ilchester Woods Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Salvatore Cammarata Stella Centenio 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph L. Torosino Son 5117 Ilchester Woods Way; Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 8/27/2007 Baltimore, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Juneral Service Licensee Semmer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) URINARY TRACT INFELTION I WOOK. DIFFICE DIARHEA. CLOSTRINIUM I WEEN. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2☐No 3☐ Probably 4☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury М 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

68760 Box Ö Δ. peen has GROSINO page , certificate Vital director, ō

Attending Division thin 24 hours after death.

the Funeral Director: A Hospital or

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

"natural", or Items 23a or dical Examiner must be

other than "natu

is marked

If Item 27 or other tra

permit. Page Department o Important: If any Injury or once.

Physician

/Medical Examiner

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1 and 2 should be filed within 72 hours after Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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Certification:

29a. Certifier

within 2

State Registrar

MYHAMMAD 31. Date filed (Month, Day, Year)

Warin,

29b. Signature and title of certifier



and manner stated.

 $\mathbf{M} \cdot \mathbf{D}$

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

P-18613.

29d. Date signed (Month, Day, Year)

AUGUST, 23, 2007.

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

29a, Certifier (Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 2

and manner stated.

32. Registrar's Signature

Zhanna Livshits, Medical Doctor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Livshits

9 2007

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Johns Hopkins Hospital 600 North Wolfe Street, Baltimore Maryland

29d. Date signed (Month, Day, Year)

August 28,2007

			Please Type or Pi State of I	r <mark>int in Black In</mark> Maryland / Dep					
			For State Registrar		ertificate of			Reg. No.	27693
	Physici		Decedent's Name (First, Middle, Last) MARILYN WILSON				2. Date of De Month AUG -	Day Year	3. Time of Death 6:45P
<i>,</i>	/Medic Examin		4a. Facility Name (If not institution, give street and number HAVEN NURSING HOME 5. Social Security Number 6. Sex 7.	er) Age (In yrs. last birthday	BALTI	MORE CIT		4c. County of Dea	
	Funeral Director		216-28-1167	77 Yrs.	Months Days	Hours Min.	10/19		EORGIA
	death with the Maryland ms 23a or 28a-f show r must be notified at	ctor	10a. State 10b. County MD N/A	10c. City, Town or L	ocation MORE CI	ГY			10d. Inside City Limits 1X Yes 2 □ No
	3a or 28 st be not	al Director	10e. Street and Number 3018 ARUNAH AVENUE	·	10f. Zip Code 21	216		10g. Citizen of What C	ountry?
5-0036	in 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show ledical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Date	X No	. Was Decedent of H If Yes, specify Cub	dispanic Origin? (Spe an, Mexican, Puerto l Specify:	cify Yes or No Rican, etc.)		
0-61212	within 72 ene. than "na he Medic	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4c)	(Give		pation during most of workind) ASSISTAN		16b. Kind of Business BALTIMOR HOSPITAL	E CITY
and	d be filed ental Hygi ked other c event, ti	To Be C	17. Father's Name (First, Middle, Last) CHESTER WILSON, SR.				(First, Middle,	, Maiden Surname)	-
, mary	and 2 shou salth and M 127 is mar er traumati	-	19a. Informant's Name/Relationship (Type. Print) BERNADETTE SAMUELS /	DAUGHTER	ling Address (Street 3018 AR	and Number or Rura UNAH AVE	I Route Numb	er, City or Town, State BALTIMORE	Zip Code) , MD 21216
timore	t. Pages 1 and the control of Healt rant: If item 2 rant: If item 2 rant or other		20a. Method of Disposition 1 □ Burial 2 ※Cremation 3 □ Removal from Sta 4 □ Donation 5 □ Other (Specify)	METRO (ematory or other pla CREMATOR	8/29		20c. Location - City o	LLE, MD
ga	permit. Par Departmen Important: any Injury		21. Signature of uneral Service Licensee 23a. And Enter the disease, or complications that club	aug .	4600 LIE	BERTY HEI	GHTS		TIMORE, MD
	Physician /Medicai Examiner		Imm (dish Cause (Final dise to or condition resulting in death) Due to (or	as a consequence of):	E RENA		ASE		Approximate Interval Between Onset and Death 4 4-5
	oe executed cian and vurial-transit	Examiner	Sequentially list conditions D. — — — — — — — — — — — — — — — — — —						
68/60,	cate be exe physician a the burial-t	-							140
.O. BOX	law requires that the death certificate be as been signed by the attending physicia 2 should be detached for use as the bu	Physician/Medica		n 2 🗆 Fetal death 3 t at time of death 5	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of de Month	elivery Day Year
7	w requires that the de been signed by the s should be detached	þ	Part II. Other significant conditions contributing to deat	h but not resulting in the	underlying cause giv	ven in Part I.		tobacco use contribute Yes 2□ No 3□ F	to the cause of death? Probably 4 hnknown
vital Records,	The ate has	Completed					24a. Was auto perfo 1□ Yes	an 24b. Were a prior to death?	
r VII	nding Physician: th. : After this certifics ? funeral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inp	atient 2 ☐ ER/Outpatie	ent 3 DOA Oth	26. Place of Death ner: 4 Nursing Ho		o <i>ne)</i> idence 6 ⊟Other <i>(Sp</i>	ecify)
DIVISION OF	the Hospital or Attending Physician: the 24 hours after death. The Euroral Director: After this certifical thetely filled in by the funeral director,	Certification:	2 Accident investigation	Day Year) Injury	of 28c. Inju Wo M 1	ry at rk?] Yes 2 □ No	28d. Describe	how injury occurred	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 Homicide determined building.	injury - At home, farm, s , etc. (Specify)			City or To	(Street and Number or F wn, State)	
	he Hosp in 24 hou he Fune pletely fil	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the beside and manner	s of examination and/or i					
)	To t To t	M	29b. Signature and tittle of certifier	DENTINO	29c. Licens	se number 3 o 4 9 4		29d. Date signed (Mor	
3	7		30. Name and address of person who completed cause of the state of the	en choice la	one su	'he 3 c2 (Catons	sville mis	3148
V	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 9 2007	istrar's Signature	we	-			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Physician ames S. Wilson 10:35 PM 08 24 - 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Coastal Hospice at the Lake Salisburg WICOMICO If Under 1 Year | If Under 24 Hrs. | Months Days Houle Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1**X**M 2□F 78 213-26-8801 7,1929 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1 □Yes 2 No Director Maryland Wicomico Salisbury 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Drive Ext. Apt#4 21801 USA Riverside by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Dives 2 □ No If Yes, Give Year or Dates: Korean War 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 □ Widowed 4 X Divorced permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Georgia Missell Morrison James Sheridan Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2357 Del Amo Blud, Torrance, CA 90501 Ex-wife Elaine Wilson / 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry August 28,2007 Hanover, MP 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anadomy Gifts Registry 21. Signature Funeral Service Licensee 7522 Connelley Drive Suit P. Hanover, MD 21076 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or cardilion Immediate Cause (Final disease or condition resulting in death) accumone with **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Examine that the death certificate be executed burial-trans Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) P.O. I signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an certificate 2**/2** No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 FlOther (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🔀 No မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 □ Yes 2 □ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Registrar DHMH 17 Rev 1/2001

State

(Check only one)

31. Date filed (Month, Day, Year)

AUG 29

20. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print)

GREGORIO M. BELLOSO, M.D., 5302 CHINABERRY 32 Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) 08-25-2007 07-06354 Tammie Wilkens

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			- For State - Certificate of Death	Reg.	No. 2	7 2769
	Physicia	ın/	1. Decedent's Name (First, Middle,Last)	Date of Death Month D	ay Year	3. Time of Death 0846 hrs
Med	dical Exami	ner	4a. Pacility Name (if not in titution, give street and number) 4b. City, Town, or Location of Death	August 17, 2	4c. County of Death	
U 24			905 Evesham Avenue Baltimore	10.75		,
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.			hplace (State or
	Director		220-80-1186 1 M 2 KF 46 Yrs. Months Days Hours Min.	5-18	-1961 co	untry) 1
101	any		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location			10d. Inside City Limits
2	* .		MD Baltimore			1 Yes 2 No
3	Maryland 28a-f show d at once.	Director	10e. Street and Number 10f. Zip Code	10g	Citizen of What Cou	ntry?
	72 hours after death with the Maryland "natural", or items 23a or 28a-f she al Examiner must be notified at once		905 Evesham Avenue 21212		USA	
	th with ems 2; f be n	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 3. Was Decedent of Hispanic Origin? (Sp. 15 Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer White, etc.	can Indian, Black,
	er dea		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: P	lack
	urs aft tural' amine	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of v		6b. Kind of Business/	Industry
	6 172 ho an "na	pleted	Elementary/Secondary (0-12) College (1-4 or 5+)	-		
	5-003 ited within Hygiene. I other the	E .	17. Father's Name (First, Middle, Last) Supervisor 18. Mother's Name	(First Middle Ma	Irans	DITATION
	21215-0036 uld be filed within 72 Mental Hygiene. marked other than c event, the Medical	BeC				
		2	Richard Wilkins Elai 19a. Informant's Name/Relationship (Type, Print Ducker) 19b. Mailing Address (Street and Number or F			
	nore, MD 2121 ages 1 and 2 should be fi nt of Health and Mental tt: If item 27 is marked other traumatic event,	. 3	Tewel S. Brittingham 905 Evesham Au 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery,	re Bal	Oc. Location - City or	2/2/2 Town, State
	Ore, ges la tof He tof He ther t		1 Percent 2 Commercian 3 Permayal from State crematory or other place)	1		
	the Fire		4 Donation 5 Other Specify: King Menorial Fuel 8/3 21 Signature of Funeral Service Licensee	107K	DUITING	re, MD
	Bal permit Depar Impor injury	1	170 (17+0 MU1362) 4405 Capic Co	X · Baylo	6 MD 2	1212
	Physician		23a. Par I. Enter the disease, or confiderations that caused the death. Do not enter the mode of discussions as cardiac of failure. List only one cause on each line.	or respiratory arrest	t, shock, or heart	Approximate Interval Between Onset and
F 4	/Medical Examiner	8 11	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			Death
1			or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b			
		aminer	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
	4	Exam	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
V	executed an and al - trans		d.			
	o, e be ysici buri	ledical	X unpended X amended Inf., 1,23a,27,perME,g871, 9/26/07 T.	Γ	23d. Date of deliver	
	1876 tificat ing phr as the	≥	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ancy		y Day Y ear
	ion of Vital Records, P.O. Box 687 tending Physician: The law requires that the death certificath. Tor: After this certificate has been signed by the attending the funeral director, page 2 should be detached for use as t	Physician/	4 Pregnant at time of death 5 Other (Specify)			
	by the chedren	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
	P.O. es that the signed by be detac	d by		1 Yes	2 🗸 No 3 Pro	bably 4 Unknown
	rds requi	lete		24a. Was an		utopsy findings available completion of cause of
2	i of Vital Records, ing Physician: The law requir After this certificate has been s uneral director, page 2 should I	Completed by		perform 1 ✓ Yes 2		es 2 No
1st+ (nst)	Vital Rec ysician: The l his certificate l director, page	Be C	25. Was case referred to medical examiner?			
+	Physic Physic rathis	Tof	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Nursin		esidence 6 Othe	r: Scene
	on of \alpha of	ion:	27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 1 X Natural 5 Pending	Zou. Describe no	w mjury occurred	
T.		ficat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.			ural Route Number, City
Name	Dival or pital or ours affilled in	Certification:	Suicide 6 Could not be determined (Specify)	or Town, Sta	te)	
7	Division To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and one)	d due to the cause	s) and manner as sta	ted.
1	To th withii To th	Medical	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	
_	_	==	O.C.M.E.	i	August 18, 2007	
			30. Name and ad ress of person who completed cause of death (Item 23a)			
	Ø		Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
	S Regis	tate	31. Date filed (Month, Day, Year) AUG 2 9 2007 32. egistrar's Signatur			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1154PM 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMOR Medical NIA Center Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 217-38-626 6. Sex Months 1₽M 2□F Davs Hours Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Nes 2 No MARYLAND g. Citizen of What Country? 10e. Street and Number Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 💢 Married 1 ☐ Yes 2 🕅 No Specify: BLACK 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MGRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type., Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHEILA Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 □Cremation 3 □Removal from State BALTIMORE 4 □ Donation 5 □ Other (Specify) 2140 N. EVHOR AVERGE 21. Signature of Funeral Service Licenses 22. Name and Address of Vacility Joseph 1 to me MO 21219 Drown, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Heute myseardial Due to (or as a consequence of): Lours 10 Coronary Sequentially list conditions, if any, leading to firm solute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2XER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

by Funeral

Be Completed

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Funeral

Director

1 and 2 should be filed within 72 hours after death with the Maryland

Maryland

3altimore,

Pages

Department of Health and Mental Highen. Industries are seen with the State of Sa-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

be executed burial-transi the use as for signed by the a page 2 s certificate Hospital or Attending Physician:

P.O.

Records,

Division or Vital

After this certification funeral director,

Examiner

Physician/Medical

Completed by

Be

Medical Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes

5 Pending investigation

28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

21217

29a. Certifier (Check only one)

1 Natural

2 Accident

4 Homicide

3 Suicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

EVAW

Place

29b. Signature and title of certific

6 ☐ Could not be

7 43386 W5)

29d. Date signed (Month, Day, Year) 08.27.07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

1 to wond 32. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 2 9

within 24 hours arter occ...

To the Funeral Director: Aff

			For State Registrar	State of Ma	aryland	-	artment of H ertificate of I			iene eg. No.	107	2.7597
	e y w	7	Decedent's Name (First, Middle	, Last)					2. Date of Dea Month	th Day	Year	3. Time of Death
12.	Physicia /Medic	Mattie Watson August 18							18 2	2007	9:50a ^M	
	Examin	er	4a. Facility Name (If not institution	,				Location of Death		4c. Cou	nty of Deat	th
			1218 Walker 7	1.000	B e (In yrs. Ia	st hirthday	Balt) If Under 1 Year	imore If Under 24 Hrs.	8. Date of Birth		NA 9. Birt	hplace (State or Foreign
i.	Funeral Director		220-24-5987	1□M 2\ F	85	Yrs.	Months Days	Hours Min.	(Month, Day 7-24-	, Year)	Co	N.C.
	70		Usual Residence of Decedent			Town and						
	arylar show	ř	10a. State 10b. County		TUC. City,	Town or L						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the M 28a-f iotifie	Director	Md. 10e. Street and Number	NA		E	Baltimore 10f. Zip Code		1	0g. Citizen o	of What Co	23
	with 3a or 1 be r	Ö	1218 Walker A	ve Ant B				239			JSA	,
	death ms 2:	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S	. 13.	Was Decedent of H If Yes, specify Cuba		pecify Yes or No-		lace - Ame	erican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced		10		1 ☐ Yes 2 ☐ No	Specify:	o rican, etc.)		cify: Bla	
2	72 hc 'natur dical	Completed	15. Decedent (Specify only highes	's Education st grade completed)	1	(Give	edent's Usual Occup e kind of work done	durina most of wor	king	16b. Kind of	Business/	Industry
12	within ene. than '	du	Elementary/Secondary (0-12) 8th grade	College (1-4or 5	i+)		DO NOT use retired Sing Assi	<i>'</i>		Vario	ນາຊ	
	filed v Hygie sther i		17. Father's Name (First, Middle,	Last)		Mul	LEGA PILLE.		ne (First, Middle,			
an	ild be lental ked o ic eve	To Be	George		Watk	ins		Roset	ta	Marı	COW	
Maryland	shou and M s mar	٦	19a. Informant's Name/Relations	nip (Type. Print)		19b. Mail	ing Address (Street	and Number or Ru	ral Route Numbe	r, City or Tov	vn, State, 2	Zip Code)
	and 2 salth a n 27 li		Mary Boykins	Daughte			18 Walker		t. B, Ba			
altimore,	Pages 1 nent of He ant: If Iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		_		osition (Name of ematory or other place nount Cer	1	Date 25-07			Town, State
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service	Licensee	me	2	22. Name and Addre		March F.M	H. Eas	t Md.	21202
	*		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each lin	the death.	Do not er	nter the mode of dyir	ig, such as cardiac	or respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. CARD/ Due to (or as		10 P	ATHY					Onset and Death
	/Medical Examiner		resultin g in death)	Due to (or as	a conseque	ence of):		_				
1	Examine	_	Sequentially list conditions,	b. CORO/			RTERY	DISE	ASE			
7	ted nsit	nine	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequi	31105 01).						
_ `	icate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as	a conseque	ence of):						
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.O. Box	The law requires that the death certif ate has been signed by the attending bage 2 should be detached for use as	Physician/M	in the past 12 months? 1						Date of de Month	livery Day Year		
<u>~</u>	hat th d by t		9 ☐ Unknown Part II. Other significant condition	ons contributing to death b	ut not resul	ting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use c	ontribute to	the cause of death?
Records, P.	uires tha signed I d be det	d by	, a				,,		1 🗀 Y	es 2□N	3 □ P	robably 4 Unknown
S	w requir been si should I	Completed					_		24a. Was a	n 24	h. Were a	utopsy findings available
æ	he lav e has ige 2	dmo							autop perfor	sy med?	prior to death?	completion of cause of
	ysician: The is certificate hadirector, page	Be Co	25. Was case referred to medical					26. Place of Dea	1 Yes ath (Check only or	2 No	1 □ Yes	s 2 2 1√No
<u>-</u>		To B	examiner? 1 ∐ Yes 2 ☑ N o	Hospital: 1 ☐ Inpatie	ent 2 🗆 E	R/Outpatie	ent 3 DOA Oth	er.	lome 5 Aesid		Other (Spe	ecify)
Division or Vital	ding Ph h. After th funeral	L :uc	27. Manner of Death 1 ✓ Aatura! 5 ☐ Pendin	28a. Date of Inju	ry y Year)	28b. Time Injury		y at k?	28d. Describe h	ow injury oc	curred	
Sio	Attending r death. ector: After by the fune	atic	2 ☐ Accident investig	jation			M 1□	Yes 2 □ No				
Ž	or Attend fter death Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ		ury - At hor c. <i>(Specify)</i>	ne, farm, s	treet, factory, office		28f. Location (S City or Tow	treet and Nu n, State)	mber or R	ural Route Number,
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:		29a. Certifier 1 ertifyin	g Physician: To the best	of my knou	ledge des	ath occurred at the ti	me, date and place	and due to the	ause/s) and	manner a	s stated
	T 4 F 5	edical	(Check only 2 Medical one)	Examiner: On the basis o and manner st	f examinati	on and/or i	investigation, in my	ppinion, death occi	irred at the time,	date and pla	ce, and du	e to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certified	r			29c. Licens	e number		29d. Date siç	ned (Mon	th, Day, Year)
)			Man	ulla	~~	1	D	3027	_	AUC	u 5T	22,2007
•	2		30. Name and address of person				Print)					
	J						EN CHOIC	ELANE	SHITE	204 1	BATTI	MORE, MD 2122
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 9 20	32. Registr	ars Signati	ire	20					
			7.00 20 20	Jan Police Contract	500		500					

State of Maryland / Department of Health and Mental Hygiene State Registrar Amend 20c, perFH, C870, 8/29/07 TT Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day : 15 A M **Physician** WALLACE €551 € /Medical 4b. City, Town, or Location of Death County of Death 4c. 4a. Facility Name (If not institution, give street and number) Examiner OAK Crest Village 5. Social Security Number Baihmere If Under 1 Year | If Under 24 Hrs Bastimore LIVING Birthplace (State or Foreign Country) Age (In yre last birthday)
Yrs. **Funeral** Months Days Hours 213-34-8788 -10 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 10a. State or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 Mo Director Balhmore Kaltimere 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S. 8830 21234 Blyd or Itema 23a Funeral deeth permit. Pages 1 and 2 should be filed within 72 hours after deet Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or isona any injury or other traumatic even. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐Yes 2☐No 1 Newer Married 2 Married 1 ☐ Yes 2 █ No Yes, Give ear or Dates Specify. Specify: White þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Healthcare 4+ 12 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be BESSIE LRVIN 0 Kau 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cape St. Clare, Date 20c. Loca 837 Harbor View Skphanie mo 21409 P. Wallace Elkridge Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State -1-07 ballmere Meadowndoe Cemekry 4 □ Donation 5 □ Other (Specify) A Facility Bradley - Ashton Fuheral Home, 21. Signature of Funeral Service Licensee 2. Name and Address P.A. 2134 Willow Spring Rd, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician End stage DISERSE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☑No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an 15 Yes 2 No mening 25. Was case relerred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Cother (Specify) 155.54 Living Hospital: 2 No 3□ DOA Certification: To 1 Tes 1 Inpatient 2 ER/Outpatient A per tracul 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 1 Natural 5 Pending investigation 1 □ Yes 2 □ No death. 2 Accident after death Director: the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ~ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anna Mon. a.s 3600 32. Registrar's Signature 31. Date liled (Month, Day, Year) AUG 29 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) 27 2007 8:15a. August Younger Dorothy 4b. City, Town, or Location of Death 4c. Counfy of Death 4a. Facility Name (If not institution, give street and number) NA Baltimore 3405 Bateman Ave If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months 1 □ M 2 💢 F 23 39 SC 247-70-9551 67 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Y□Yes 2□No Baltimore MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A 21216 3405 Bateman Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Callagher Services Cook 12th_grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louise Thomas Jack Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Md 21216 Date 20c. Location - City or Town, State 3405 Bateman Ave, Robert Brockington-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Arbutus Memorial Park 9/1/07 Arbutus, Md 21. Signature of Funeral Service Lice - ee March F/H West 4300 Wabash Ave, Baltimore, Md hom pson 21215 11 23a. Part1. Exert the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ovarian cancer Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnance

or Attending Physician;

been signed by the attending physician and should be detached for use as the burial-tran page 2 s To the Hospital o within 24 hours aft To the Funeral Di completely filled in

Physician

/Medical

Examiner

Funeral Director

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0036

Examiner n/Medical after death.

I Director: After this of in by the funeral d

State

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d by Pr	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
complete			24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No
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ation: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Injury M 1 □ Yes 2 □ No	28d. Describe how injury occurred
ertific	3 Suicide 6 Could not b 4 Hornicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
cal C	29a. Certifier 1 CertifyIng Pt (Check only 2 Medical Example)	nysician: To the best of my knowledge, death occurred at the time, date and plan niner: On the basis of examination and/or investigation, in my opinion, death oc	ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shewe

D24170

29d. Date signed (Month, Day, Year)

N. Eutaw St Baltimore MD 21201 E. Tso MD Richey
31. Date filed (Month, Day, Year) Hospice 32. Registrar's Signature

29c. License number

(Check only one)

29b. Signature and title of certifier

AUG 2

			1 = For State Registrar	State of Maryl	-	partment of e <i>rtificate of</i>		Mental Hy	giene Reg. No.	107	27700
Š.	0	M	Decedent's Name (First, Middle,	Last)				2. Date of De	ath		3. Time of Death
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036	be filed within 72 hours after death with the Maryland Ital Hygiene. It offer than "natural", or itema 23a or 28a-f ahow avant. Ite M. diral Exa. diner calast be incilled at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever i Armed Forces? 1 Yes 2 Mo If Yes, Give Year or Dates:	n U.S. 13	. Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 🛣 No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		Race - America Black, White, e ecify: U.S.	etc.
Maryland 21215-0036		Be Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	(Giv life.		pation during most of work ad)	king		of Business/Ind	lustry
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anc	ntal he of	Be	Isaiah Akinpetio				Esthe		dinnel		
2	should od Me mark matic	ဥ	19a. Informant's Name/Relationship		19b. Mai	ling Address (Stree	t and Number or Ru				Code)
	nd 2 s lith ar 27 is r trau		Olukayode Akin		1272 (2) (2)		Lane Ft. V				
ē,	ges 1 and 2 should be filed within to f Health and Mental Hygiene. If item 27 is marked other than or other traumatic avant, the M.		20a. Method of Disposition	20	b. Place of Disc	position (Name of ematory or other pla		Date	20c. Location	on - City or To	wn, State
Ë	Pages nent of int: if th		1 Burial 2 □ Cremation 3 □ Cremation 3 □ Other (Spe	MRemoval from State cify)	· · · · · · · · · · · · · · · · · · ·	Cemetery	8/31,	/2007	Ileol	luji,Ni	geria
Baltimore,	permit. Page Department of Important: if any injury or once.		21. Signature of Furreral Service Lice	eensee		22. Name and Addr 7474 Land	ess of Facility dover Road	J. B. Je d Landov			
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	emplications that caused the day one cause on each line.	leath. Do not e	nter the mode of dy	ing, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
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	rted nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that include assets)	240 10 (01 43 4 00)	334431 03 01/.						
<u>,</u>	execun n and ial-tra	Examlner	that initiated events resulting in death) Last	c. Due to (or as a con	sequence of):					_	
08/60	ficate be executed physician and is the burial-transit	edlcal	•	d.							
_		Med	IF FEMALE:								
.O.	requires that the death certif seen signed by the attending hould be detached for use as	Physician/M	23b. Was decedent pregnanf in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	☐Ectopic pregnand	су 		23d.	Date of delive Month	ry Day Year
ras, r	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions	contributing to death but not	resulting in the	underlying cause g	ven in Part I.		obacco use d Yes 2√DN		e cause of death?
Vital Hecords,	The law ate has b page 2 s	Completed						24a. Was auto perfo 1 Yes	psy ormed?	4b. Were autop prior to con death? 1 \(\text{Yes}	osy findings available inpletion of cause of 2 X No
<u> </u>	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospitali			26. Place of Dea	th (Check only	one)		
<u> </u>	his Il di	: То	1 ☐ Yes 2 ☒ No 27. Manner of Death	Hospital: 1 Inpatient 2	2 ER/Outpatie	3111 3121007		ome 5 Resi			')
0	tending f feath. for: After the funer	tlon	1 ⊠Natural 5 ☐ Pending	(Month, Day Year	r) Zob. Time Injury	We	iry at ork?]Yes 2 □No	28d. Describe	now injury oc	curred	
DIVISION	ie Hospital or Attending P n 24 hours after death. Ne Funeral Director: After t bietely filled in by the funera	Certification:	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine	be 200 Blood of Laiver A	At home, farm, s ecify)			28f. Location (City or To		ımber or Rura	l Route Number,
	To the Hospital or Att within 24 hours after de To the Funeral Directicompletely filled in by to	edical (29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my aminer: On the basis of examend and manner stated.	knowledge, dea nination and/or i	ath occurred at the tinvestigation, in my	ime, date and place, opinion, death occur	, and due to the rred at the time,	cause(s) and date and pla	I manner as stoce, and due to	ated. the cause(s)
	To the within 2 To the complet	¥	29b. Signature and title of certifier			29c. Licen	se number		29d. Date sig	gned (Month, I	Day, Year)
			> till	ollen	-, mi	D2342	29		Augus	st 9 20	07
1	(5)		30. Name and address of person what Ton That Chie	eu M.D. 7505 N	ew Hamp	shire Ave	e # 310 Ta	akoma Pa	ırk, Ma	ıryland	20912
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 3 2007	32. Regisfrar's Si	gnature	j					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician Caroline Ayers 04:00 M 2007 turest /Medical 4b. City Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2**X** F 222-05-4535 97 5/16/1910 Del<u>aware</u> Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1 May Yes 2 □ No Director Wicomico Maryland Salisbury 10a. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1415 Riverside Dr., Apt. C303 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ğ Specify: white 3X Widowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natul any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) owner/operator Ayers Diner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (unknown) Alberta Joseph Cicatelli 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9172 Black Dog Alley, Easton, MD 21601 Paul B. Ayers/son 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition springhill Memory 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 8/13/07 Hebron, MD 4 ☐ Donation 5 ☐ Other (Specify) Gardens Holioway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Signature of Funeral Service Licensee arie X CFSP domosoo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) THENDSCLEK-DITC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Certification: To Be Completed by Physician/Medical

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely lifled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical State

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence	of):						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	n 3⊟Ectopi 5⊟ Other	c pregnancy (specify)		23	d. Date of d Month	delivery Day	Year
Part II. Other significant conditions cont	ributing to death but not resulting i	n the underlyir	g cause given in Part I.	23e. Die	d tobacco us	e contribute	to the caus	se of death?
PNEUMONIA				1 [Yes 2	No 3	Probably	4 Unknown
ATRIAL FILL DEMENTIA	BRICATION			24a. Wa au pe 1∐ Yes	topsy rformed?	24b. Were prior to death	o completio	dings available on of cause of
25. Was case referred to medical examiner?		-000	26. Place of De	ath (Check onl	v one)			
1 Yes 2 No	ospital: Inpatient 2 ER/O	utpatient 3	DOA Other: 4 Nursing I	Home 5□Re	sidence 6	□Other (Sp	pecify)	
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describ	e how injury	occurred		
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, for building, etc. (Specify)	arm, street, fac	etory, office	28f. Location City or 7	(Street and Town, State)	Number or	Rural Route	e Number,
	ician: To the best of my knowledger: On the basis of examination a and manner stated.							ause(s)
29b. Signature and title of certifier			29c. License number		29d. Date	signed (Mo	onth, Day, Y	/ear)

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 2007

31. Date filed (Month, Day, Year)

AUG 1

614

B egistrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Francis Leroy Allen, Sr. 8, 2007 August 9:10 P. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Hospital Center Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Yea 11/20/11 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1X M 2 □ F Upper Marlboro, Md. 95 Director 577-26-9661 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Director Md. P.G. Fairmount Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5804 L Street Funeral 20743 U.S.A. 4. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2√2 No African-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: Specify: þ 3√ Widowed 4 □ Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer 6th Warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Allen Mary Brice ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth B. Vaughn/Daughter 6113 State St., Cheverly, Maryland 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. 4 □ Donation 5 □ Other (Specify) Harmony Memorial Park Aug. 16,07 | Landover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ARRHYTHMIA Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of it The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of this certificate has to director, page 2 si autopsy performe death? 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No မ 27 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / 6 Could not be 3∏ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 24 within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) Name and HOSPITAL 3001 LITTLE 32. Registrar's Signature onth, Day, Year. State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 14, Year 3:50 P **Physician** S. Amper Ester /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 613 Hathaway Court Accokeek If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 18, 1952 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 1 F Hours 375-84-7757 Philippines Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Prince George's Accokeek Director with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 613 Hathaway Court 20607 USA death Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? or itema 11. Marital Status 1 ☐ Yes 2 KMNo If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2X Married Specify: Filipino Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced "naturel". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) then . College (1-4or 5+) Elementary/Secondary (0-12) Medical 4 Nurse permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: if item 27 is marked other
any injury or other traumer: other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pilar Pabingwit Bation Salvador Aquino Salarda 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William Amper / Husband 613 Hathaway Court Accokeek, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XXBurial 2 Cremation 3 Removal from State St. Mary's Ch. Cem. 08/20/2007 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Anneral Service License 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 1(11) Parti. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Breast Cancer to Liver Physician /Medical Due to (or as a consequence of): **Examiner** Metastatic Breast Cancer to Bone and Lung Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Breast Carcinoma and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of deliver 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 🖾 No 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2XXNo 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 1 Tyes director, 25. Was case referred to medical 26. Place of Death Check only one Hospital: Other: 4 ☐ Nursing Home 🐉 🖾 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Natural 4 hours after death. М 1 Yes 2 No 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) l in by 4 Homicide within 24 hours a y To the Funeral C completely filled 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatur 29c. License number and title of certifier D0020678 August 15, 2007 cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed MD Edwarda H. Buda 6825 16th Street N.W. Washington, DC 20307 32. Registrar's Signature AUG 1 5 200 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		1 - For State Registrar	State of N	laryland	•	urtment of F <i>tificate of</i>		d Mental Hy	giene Reg. No.	2007	2770
Physici /Medic		1. Decedent's Name (First, Middle, La Michael Ayo	st) Adeyey	re				2. Date of De Month August		200 ^{¥ear}	3. Time of Death 6:55 P
Examir		4a. Facility Name (If not institution, given 9011 Breezewood				4b. City, Town, o		ath	1	County of Death	eorge's
Funeral Director		389-90-9222	Sex 7.7 IXIM 2□F	Age (<i>In yrs. l</i> as 51	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		ıy, Year)	9. Birthi Cour Nige	* *
a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Md Prince G	George's	10c. City, 1	fown or Lo			V			10d. Inside City Limit
a or 28, be not	Director	10e. Street and Number 9011 Breezewood				10f. Zip Code				en of What Cou	ntry?
illed within 7 z nouts after death with the maryland Hygiene, then "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 Yes 28 If Yes, Give Year or Dates	nt Ever in U.S. s? No		2077 Nas Decedent of H f Yes, specify Cub	Hispanic Origin? Jan, Mexican, Pu	(Specify Yes or No erto Rican, etc.))-	SA 4. Race - Americ Black, White, Specify: B	
tal Hygiene. d other than "natule event, the Medical	Completed	15. Decedent's E (Specify only highest grant Elementary/Secondary (0-12)	ade completed) College (1-4o		(Give life. L	lent's Usual Occup kind of work done DO NOT use retire	during most of v	vorking		nd of Business/In	dustry
stroud be fried within and Mental Hygiene. marked other than imatic event, the M	To Be Co	17. Father's Name (First, Middle, Last Samuel Adeyeye	4yrs		Ci	vil Engi	18. Mother's N	lame (First, Middle	, Maiden	<u>ivate</u> Surname)	
f Health and Mental F them 27 is marked of other traumatic ever	-	19a. Informant's Name/Relationship	Type. Print)				and Number or	Rural Route Numb	er, City or		
5 O		Aderemi Adeyeye 20a. Method of Disposition 1⊠ Burial 2 □ Cremation 3 □ 4□ Donation 5 □ Other (Speci	Removal from Stat	e	e of Dispo netery, cren	sition (Name of natory or other pla	ce)	ad Kennes Date 7/2007	20c. Loc	cation - City or To	own, State
Department Important: I any Injury o		21. Signature of Funeral Service Lice		Talk	22	. Name and Addre	ess of Facility	J. B. Jei ad Landov	nkins	Funera	LHome
nysician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		ed the death. line. pus	Do not ent	er the mode of dyi	ng, such as card	liac or respiratory a	rrest,		Approximate Interval Between Onset and Death
/Medical xaminer	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Day 250 or injury that initiated events	b	as a consequer as a consequer		1.5	_				
physician and s the burial-transit	dical Examiner	that initiated events resulting in death) Last	cDue to (or a	as a consequer	nce of):						
een signed by the attending prhould be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 ☐ Fetal de at time of deat	eath 3	Ectopic pregnanc	у		2	3d. Date of deliv Month	ery Day Year
r requires trate. Feen signed be should be deta	þ	Trace in Solici Significant Contained in Section Dutilities underlying Gause given in France.							23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unkno		
ate has h	Completed							24a. Was auto perfo 1 Yes		24b. Were auto prior to co death? 1 □ Yes	opsy findings availab impletion of cause o
this certificate had director, page	o Be	25. Was case referred to medical examiner?	Hospital:	None OFF	NO stantina	Ott	ner:	eath (Check only o			
Affer		1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending investigation		d/Outpatien Bb. Time of Injury	28c. Inju Wo	4 LI Nursing		5 X Residence 6 ☐ Other (Specify) Describe how injury occurred			
Dir	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	building,	etc. (Specify)		eet, factory, office		City or To	wn, State)		al Route Number,
Fur ely	ledical		nysician: To the bes miner: On the basis and manner	of examination							
To the I	Me	29b. Signature and title of certifier	locald	w)	29c. Licens D12	se number		29d. Date signed (Month, Day, Year) August 7, 2007		
.(4)		30. Name and address of person who Eduardo Flores 31. Date filed (Month, Day, Year)	M.D. 5711		is Av	*	02 Rive	rdale, Ma	ryla	nd 20737	,

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 305 Frieda Sophie Baynard 9,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Rehab + Nursing Ctr.

6. Sex 7. Age (In yrsuast birthday) Salisburg
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Year! 1 □ M 2 🔼 F Days Min Yrs. 218-24-3949 Director Nov. 18, 1927 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director MD Wicomico Salisbury 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 200 Civic Avenue 21804 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No ò Specify. Specify: white 21215-003 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Home Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Degen Anna Meyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra 30554 Cannon Drive Salisbury, MD Betty Matlick (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fireman's Cemetery Aug. 12, 2007 Sharptown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Short Funeral Home Grove Street Delmar, DE 23a. Part1. Enter the shock, or heart s lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each ling. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) erelyono **Physician** ec21-THE CA /Medical Due to (or as a consequence of) Examiner Day. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) Records, P.O. 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires 1 ☐ Yes 2□ No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed Yes 2 No Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 2 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

William H. Robins, n.D.

32. Registrar's Signature

200 Civic

Ave. Salsbury in D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 4onth Jr **Physician** DUNTING 2007 SUMPAN hester /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Talbot Easton Nemorial Hospita If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1**X**M 2□ F 222-30-1978 60 MAY DELAWARE Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at MD 1 Yes 2 No Greeksboro Director AROLINE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21639 U.S. A. Sunset AVENUE WEST Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗖 No Specify. Specify: W. Viite Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 1972 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Autorioloile CAR SAlesman 2 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bunting Joyne DUNTING HATTIE ewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) wife 711 West Sunset (reensboro M) 21639 Bursties Ave MARY CHEN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Aug. 15, 2007 LAPITEL Cremator 4 Donation 5 Dother (Specify) Signature of Funeral Service Lic 12 S. 2KD STREET 22. Name and Address of Facility MOORE FUNERAL HOME DENTON, IND 21629 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) day Acute Myocardia **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, learning to firm solutions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for an e-gonsequence off Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an was ... autopsy performed? Vas 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 1 ☐ Yes Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Injury (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my entirior, death accurred at the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and D0053815

State Registrar 31. Date filed (Month, Day

DHMH 17 Rev 1/2001

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Moon

8/1x/2007

MARKET STREET DENTON MA 2/629

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10,2007 4:45p M August Rodgers M. Brown /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceci1 Union Hospital E1kton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. | Months | Days | Hours | Min. | March | Day Year) | 1936 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Months 71 MD Director 215-32-6280 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location ms 23a or 28a-f show must be notified at 10d. Inside City Limits Director Maryes 2 No Ceci1 MD E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 132 East High St. U.S.A. 7 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must b death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. should be filed within 72 hours after on Mental Hygiene. marked other than "natural", or iter 1 Never Married 2 Married 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Charles R. Brown Oil Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Charles Brown Olive Simmons and l 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traum once. Elizabeth Maresca/Companion Rosemont Circle, Elkton, MD 21921 18 N. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State August 4 ☐ Donation 5 ☐ Other (Specify) Ferris & Co. West Chester, pA 2007 21. Signature of purplai Service Licensee 22. Name and Address of Facility Andrew G. Gee Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mile of dying, such as cardiac of respiratory arrest, stock, or heart failure. List only one cause on each line. 21921 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Amyoteophic **Physician** years /Medical Due to (or a a conseque ce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed sician and burial-trans Due to (or as a consequence of): signed by the attending physician be detached for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2□ No 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Impatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Hospital or Attending Plant hours after death. 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 🛮 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Do023322 8.13.07 achder SMD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. S. SACHDEL)

MD

118 North 118 North St Suite 3B Elham MD 21921 31. Date filed (Mont State

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Registrar

Please Type of int in Black Indelible Ink. Ensure All Constant Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Physicia		Registrar 1. Decedent's Name (First, Middl	e,Last)					2. Date of Death		3. Time of Death
al Examir		Dale Lee Baker	c					Month August 10,	2007 **eai	1253 hrs
		4a. Facility Name (if not institution, give street and number) Doctors Hospital 4b. City, Town, or Location of Death Lanham 4c. County Prince C								
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24Hrs Hours Min.		(MM/DD/YYYY) 9. B	irthplace (State or ignMaryland ountry)
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D.		M. hom Bra	enel M	D		0.0	.M.E.		August 11, 20	07
, ,		30. Name and address of person Melissa Brassell, MD		ause of death (Ite Medical Exam		Penn Street, I	Baltimore, MI	D 21201		
S	tate	At IIs 1	4 2007 32.	egistrar's Signa	ature	2 -0				
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			Decedent's Name (First, Middle	, Last)					2. Date of Deat	h	3. Time of Death		
	Physici		Barbara Sue Be	al (aka	Barbara	Sue B	eall)		August	12 2007			
)	/Medio Examin		4a. Facility Name (If not institution	·				Location of Death		4c. County of De			
			Carroll Hospice	Dove Hou	ıse		Westmin	ster		Carro	11		
	Funeral		5. Social Security Number	6. Sex				If Under 24 Hrs.	8. Date of Birth	9. 6	Birthplace (State or Foreign		
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	or 21	Sire	10e. Street and Number				10f. Zip Code		10	0g. Citizen of What	Country?		
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DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

Gloren & Spark

32. Registrar's Signature

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vonth Year **Physician** Best John Lawrence 2007 432 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Staton Driv owie 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 27 1944 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Days Hours Min. Trinidad Dec 62 577-76-7569 Director Usual Residence of Decedent 10c. City. Town or Location 10a State 10h County 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be notified at Prince George's 1 Yes 2 No Md BOWIE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20774 16 Staton Drive Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married **Black** Baltimore, Maryland 21215-0036 1 ☐ Yes 2 █XNo þ Specify 3 ☐ Widowed 4 ☒ Divorced "natural" Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) other than College (1-4or 5+) 12th Nurse Assistant Private 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance and Mental H Muriel Best William Clark ပ Pages 1 and 2 should tent of Health and Mer 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i ,Maryland 20774 16 Staton Drive <u>Joycelyn Carr/Sister</u> Bowie 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Riverdale Crematory 8/14/2007 Riverdale, Maryland 21. Signature of operal Service Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7474 Landover Road Landover, Maryland 20785 Approximate Interval Between Onset and Death Immediate Cause (Final Physician Complicati disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine certificate be executed burial-transil and resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 ☐ Other (specify) signed by the a d be detached for P.0. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☑ No page 2 s has autopsy perform 1 2□ No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To this To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral! 27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 TYes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

State Registrar

OVO

DHMH 17 Rev 1/2001

AUG 1 5 2007

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

32. Registrar's Signature

3001

30. Name and address of person with completed cause of death (Item 23a) (Type, Print)

29c. License number

100-0			For State Registrar		State o	f Marylar	•	artmen tificate			and M		Reg. No.	007	27	713
4	Physicia		1. Decedent's Name (First, Middle	e, Last)								2 Date of Dea Month	Day	Yea	r	of Death
	/Medic		Gladys		May		Boy.					August 14			11:2	O A M
	Examin	er	4a. Facility Name (If not institution	-	et and nu	mber)				Location o	f Death			County of De		
di	1 3	3	5406 Virginia Cou			7 Ann //n	is as birth day.	Oxon If Under	Hill 1 Year	If Under:	24 Hrs	9 Date of Bid		rince G		o or Foreign
100	Funeral Director		5. Social Security Number 199–20–1614	6. Sex 1 ☐ M	2 4 F	7. Age (In yrs. 83	Yrs.	Months	Days	Hours	Min.	8. Date of Bird May 7, I	924 ^{ar)}	Peni	irthplace (Stat Country) nsylvania	a or Foreign
	and w	}	Usual Residence of Decedent 10a. State 10b. County	,		10c. Ci	ity, Town or Lo	cation							10d. Inside	City Limits
	a-f sho	tor	Maryland Prince	George	e's		Oxon H	i11							1 □ Y	es 🛣 No
	with the	Director	10e. Street and Number 5406 Virginia Co	nirt				10f. Zip	Code 0745				10g. Citi	zen of What (USA	Country?	
	na 23	Funerai	11. Marital Status		. Was Dec	edent Ever in U	J.S. 13.			spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)		14. Race - Ar	nerican Indian	
36	72 hours after death with the Maryland natural, or Itama 23a or 28a-f show dical Examinat must be notified at	by Fun	1 Never Married 2 Mar 3XXWidowed 4 Divorced	i	Armed For 1 Test Yes, Gir Year or D	2 X XNo ve	•	fYes, spec 1 ☐ Yes 2		n, Mexican Specify:	ı, Puerto	Rican, etc.)		Black, Wi Specify:	White	
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21	filed within Hygiene. other then	PO.	8					Homem	aker				I.	n Home		
Maryland 21215-0036	d ia b	To Be (17. Father's Name (First, Middle, Charles Ricka							18. Mothe		e (First, Middle, el Pennii		Sumame)		
Mary	d 2 should th and Men 7 ie marke traumatic		19a. Informant's Name/Relations Deborah Boyle Hicke			_						A Route Number				
வி	of Health item 27 other tr		20a. Method of Disposition	±y / 1Æ	augrice.	20b.	Place of Dispo	sition (Nan	ne of	- 1		Date			or Town, State	1
E	Page:		1 📆 Burial 2 □ Cremation 4 □ Donation 5 □ Other (\$		noval from	State	ntico Na	t'1. C	emete	ry O	8/16/			tico, Vi		
Baltimore,	permit. Pages Department of t important: if ite any injury or of once.		21. Signatur Fundary Service	Licensee	8	Ives						eorge P. 1 kon Hill,			. Home PA 20745	I
- to	.8.		23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complica	tions that	caused the dea	Do not en	er the mod	e of dyin	g, such as	cardiac	or respiratory a	rrest,		Approxi	Between
Ę.	Physician		Immediate Cause (Final disease or condition	_ a.		Canc	n of	Pamo							Onset a	nd Death
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	/Medical Examiner		resulting in death)		Due to	(or as a conse	quence of:									
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	Due to	(or se a conec	quaries of):									
Ď,	te be executed ysicien and te burial-transit	Examiner	that initiated events resulting in death) Last	c.	Due to	(or as a conse	quence of):									
8760,	T	icai		d												_
P.O. Box 68	The law requires that the death certifica site has been signed by the ettending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	230	1 Live	tcome of pregroith 2 Fet hant at time of lown	al déath 3[∃Ectopic pr ∃ Other (sp		'				23d. Date of o Month	delivery Day	Year
	uires that n signed b ld be deta	ρ	Part II. Other significant conditi	ions contri	ibuting to d	leath but not re	sulting in the u	nderlying c	ause give	en in Part I	٠	23e. Did t	-	200	to the cause Probably 4	
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of	Physician: rthis certifice ral director, p	2	1 ☐ Yes 2 ☒ No 27. Manner of Death		1	Inpatient 2	ER/Outpatie			4 🗆 140	ursing H	ome 5 Resi			pecify)	
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Division	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could	-	28e. Place	e of Injury - At I ling, etc. (Spec	home, farm, st					28f. Location (City or To			Rural Route I	Numb e r,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	sai Ce	29a. Certifier 1 X Certifyi (Check only 2 Medica	ing Physic	cian: To th	e best of my kn	nowledge, deal	h occurred	at the tin	ne, date ar	nd place,	and due to the	cause(s	and manner	as stated.	50(5)
	the H iin 24 the Fi	Medicai	one)		and mar	ner stated.	and and of it				an occur	199 at tile tille,				
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	W		P HILM K	Celo	reun	W30 M	1 K		12	1501	6			8/14/	UT	
	3		30. Name and address of person	n who coly	pleted cau	se of death (Ite	m 23a) (Typa	d B	VUV	rch t	tre.	CIN	nto:	m/)	m) 2	0735
1	Sta Registr		31 AUG 1 5 2007 CO	here	32.	egistrar's								1	1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Year **Physician** Benjamin 12:32a^M Maddox Butler 10, 2007 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Villa Rosa Nursing Home Mitchellville Prince Georges If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1XM 2□ F 577-60-6551 95 Director 16, Washington, D.C NOv. 1911 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at Director 1√ Yes 2 No Maryland Prince Georges Mitchellville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3800 Lottsford Vista Rd. 20721 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 1 Yes 2 □ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black þ 3 ☑ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Government Printing Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be ealth and Mental and Mental Benjamin Thomas Butler Cecilia Maddox 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a

If item 27 is
or other train John Jackson / Great Nephew 811 Arbor Park Place Mitchellville, Md. 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once, 4 □ Donation 5 □ Other (Spepity) Maryland National Aug. 16, 2007 Laurel, Md. 22. Name and Address of Facility
Alexander S. Pope. P.A.
5538 Mariboro Pike/Forestville, Md. 21. Signature of Funeral Service Livensee 20747 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dual (or as a consequence of): diovencula 18an /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy signed by the atter in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 3 cate has been significant cannot be page 2 should be 1 🗌 Yes 2 No 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 1∐ Yes 2 🔀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ∑kNo 1 Inpatient 2 ER/Outpatient Certification: To 3□ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 ☐ Pending investigation Injury 1 □ Yes 2 □ No or Attendate death. 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital 24 hours a 29a. Certifier 1 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

AUG 1 5 2007



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rakesh Arora, M.D.

14300 Gallant Fox Lane, Suite222 Bowie, Md.

20715

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AND TITM23a par Physical Republic of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death August Physician To, 2007 CUMMINGS 5:15 AM HELEN MARIE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick
If Under 1 Year | If Under 24 Hrs. Frederick Frederick Memorial Hospital vrs. last birthday) 8. Date of Birth Month Day, Year 929 9. Birthplace (State or Foreign Age (In) 78 **Funeral** Days Hours 218-24-9461 1 □ M 2 💢 F Mary Tand Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show iral", or Items 23a or 28a-f shov Examiner must be notified at 1X Yes 2 □ No Frederick Frederick Maryland Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21701 U.S.A. 324 Thomas Avenue "natural", or Items 23a Funeral permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23 any injury or other traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married White 1 □ Yes 2 No Saltimore, Maryland 21215-0036 Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Store Clerk Drug Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nellie Virginia Bartlett Earl Hargett ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 324 Thomas Avenue, Frederick, MD 21701 Mrs. Patricia E. Sines, daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Mount Olivet Cenetery Aug. 13, 2007 Frederick, MD t Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22Keeney and Basford PA Funeral Home MO0255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Massive Intracerebral Intraventricular Bleeding Spotaneous 48 Hrs. /Medical Due to (or as a consequence of **Examiner** Se mentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9☐ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ No No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To Date of Injury 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

31. Date filed (Months Par Year AUG 2

(2017) 9 2007 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

23a) (Type, Print) 1987-J. D. # 207 Fred Fred Frich, Med 21202

			r icas	• •	der indelible ink. Ensure	•	•					
			1 _ For State	State of Maryland	d / Department of Health and	Mental Hygien	e					
			Registrar		Certificate of Death	Reg. No						
	Dhysini		Decedent's Name (First, Middle, I	1	2	2. Date of Death Month Da	3. Time of Death					
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	Examir		4a. Facility Name (If not institution, g	give street and number)	4b. City, Town, or Location of Deat	h 40	c. County of Death					
			HOLY CROSS	HOSPITAL	SILVERSPRING	S M	IUNTGOMERY					
	Funeral	15.0	Social Security Number 6	. Sex 7. Age (In yrs. I	last birthday) If Under 1 Year If Under 24 Hrs	8. Date of Birth						
	Director		299-50-1389	12M 2DF 65	Yrs. Months Days Hours Min.	1114/194	2 VIRGINIA					
	D		Usual Residence of Decedent									
	nylar how		10a. State 10b. County	10c. City	y, Town or Location		10d. Inside City Limits					
	Ma 1-8	흕	DC	INA	SHINGTON		1 VZYes 2 □ No					
	5 28	i.e	10e. Street and Number		10f. Zip Code	10g. C	itizen of What Country?					
	h wil	a C	533 16th StRA	FIN.E.	20002	U:	SA					
	deat	Je	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		Specify Yes or No-	14. Race - American Indian,					
9	atter or its	T.	1 Never Married 2 Married		1 ☐ Yes 2 No Specify:	to rican, etc./	Black, White, etc.					
21215-0036	hours atter death with the Maryland tural', or Items 23a or 28s-1 ehow al Examinar must be notified at	Completed by Funeral Director	3 Widowed 4 ☐ Divorced	Year or Dates:	TEL TES 25 NO Specify.		Specify: BIACK					
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21	within ene. than "	ğ	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)	A. I.	01 0000000					
21	giene.	Š	12		CUSIODIAN	C'K	S PHARMACY					
P	be filed tal Hygid d other event, I	Be (17. Father's Name (First, Middle, La	st)	18. Mother's Na	me (First, Middle, Maide	n Surname)					
<u> </u>	Mental Mental arked o	To E	HENRY CHAM	BERS	HNNA	POPE						
Maryland	S D E E		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Address (Street and Number or R.	ural Route Number, City	or Town, State, Zip Code)					
Σ	nd 2 alth e 27 is		ADDIE SOHNBONS	/ FRIEND	1311 Ft. SHEVENS DR. A	IN #2 WAS	HINGTON DC ZOOLI					
ā,	f Hei		20a. Method of Disposition	20b. P	face of Disposition (Name of	Date 20c. I	Location - City or Town, State					
20	ages ant of t: H	1 8	1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	Hemoval from State	emetery, crematory or other place) 2MONY MEMORIAL 8/1	5/2007 /1	MIDNIER MA					
Baltimore,	ntime ritari		21. Signature of Funeral Service Lice		22. Name and Address of Facility	JORAV E	IN LERO HOME					
Ba	permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tra ance.		Distri	Road	112011C - 20 - 11	= A(UI h)no)	110CC-4 11010CC					
			230 Barti Enter the disease or as	emplications that caused the death	n. Do not enter the mode of dying, such as cardia		Approximate					
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Вох	th ce	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal			23d. Date of delivery Month Day Year					
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ō	s atte	Certification:	4 Li Homodo	building, etc. (Specify	"	City of Yours, Sta	16)					
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier Certifying	Physician: To the best of my kno	wledge, death occurred at the time, date and plac	e, and due to the cause(s) and manner as stated.					
	n 24 he Fi	Medical	one)	and manner stated.	tion and/or investigation, in my opinion, death occ	urred at the time, date at	nd place, and due to the cause(s)					
	To the within 2 To the complex	Σ	29b. Signature and title of certifier	70.	29c. License number		Pate signed (Month, Day, Year)					
A	6		I and	John Di	D H006458	8	3/13/07					
)	[4)		30. Name and address of person wh	no completed cause of death (Item	23a) (Type, Print) ASHISH TOL	IA						
	(1)		Holy CROSS H	OSPITAL 1500	O FOREST GIEN RO	SIVERS	DRING MO 20910					
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100	Registr	ar	AUG 1 3 2007	Berew D. Pp	wa							

DHMH 17 Rev 1/2001

			For State Registrar	State of	of Maryla	nd / Depa	rtment <i>tificate</i>			and M	ental I		6.5	- 117	9771
	71	9 (7a	negistrar Decedent's Name (First, Middle, La	st)		001	imoato	01 2	Jean		2. Date of				3. Time of Death
	Physicia /Medic		Deborah		W.	Carmo	n				Month Aug	gust	Pay 7	2007	6:50 P M
•	Examin		4a. Facility Name (If not institution, give						Location of	of Death			4c. Count	ty of Death	
			Washington Adven 5. Social Security Number 6. S				Take		Park	04 Um I			lontg	omery	
	Funeral Director			ex □M 2 X F	7. Age (In yrs	. <i>last birthd</i> ay) Yrs.		Days	If Under	Min.	8. Date of (Month) Jan	, $D_{\mathrm{a}y}$, Y_{e}	ar) 950	9. Birthpl Count	ace <i>(State or Foreign</i> ry) Carolina
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	arylan show d at	_	10a. State 10b. County		10c. C	ity, Town or Lo	cation							10	d. Inside City Limits
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	ms 23	Funeral Director	11. Marital Status	12. Was Dec	cedent Ever in	J.S. 13. \	Vas Decede f Yes, speci	ent of His			cify Yes o			ace - America	ın Indian,
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	1 ☐ Never Married 2 【 Married 3 ☐ Widowed 4 ☐ Divorced	Armed F 1 ☐ Yes If Yes, G Year or [23€ No ive		f Yes, speci I □ Yes 2		n, Mexicar Specify:	ĭ, Puèrto I	Rićan, etc.)	Speci	ack, White, e ify: B1a	
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3	Physician: The la this certificate had ral director, page 2	a	25. Was case referred to medical						26. Place	of Death	1□ Y		No	1 ☐ Yes	2 1€ No
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-	ng Pl		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date (Moi	e of Injury nth, Day Year)	28b. Time of Injury	28	Bc. Injury Work	at ?	2	28d. Descr	ibe how ir	njury occu	ırred	
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	i or Attending Ph after death. Director: After th I in by the funeral	Certification:	4 ☐ Homicide determined	build	ding, etc. (Spec	nome, farm, stre cify)	et, factory,	office		2	28f. Location City of	on (Street Town, Si	t and Nun tate)	nber or Rurai	Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 ☑ Certifying Ph (Check only 2 ☐ Medical Exa	miner: On the	basis of examir	nowledge, death	occurred a	at the tim	ne, date an pinion, dea	id place, a oth occurr	and due to red at the ti	the cause	e(s) and r and place	manner as st	ated. the cause(s)
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)	(10)		30. Name and address of person who Yeheyis Negussie				Print)			Sil	ver s				
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** P 2:03 PM $A_{\cup Q}$ 2007 Coleman Andrew /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Balti more of Maryland Med Center University

5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours October, 301 955 Days SC 248-02-7620 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. Instituted to the than "natural", or items 23a or 28a-f show mit: If item 27 is marked other than "natural", or items 23a or 28a-f show my or other traumatic event, the Medical Examiner must be notified at my or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Funeral Director Calvert Prince Fredrick 10g. Citizen of What Country? 10f, Zip Code 10e Street and Number 4020 Dares Beach Road 20678 USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: Black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12th College (1-4or 5+) Truck Driver private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edroy Coleman Elizabeth Shrapshire 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20678 19a, Informant's Name/Relationship (Type, Print) 4020 Dares Beach Road Prince Fredrick MD Rosie Collins Aunt 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Cedar Creek 8/16/2007Lacaster, SC 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
W. Wesley Chavis III FUneral Service INC
10684 Southern MD BLVD Dunkirk MD 20754 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pulmonary Immediate Cause (Final disease or condition resulting in death) Fibrosis /Medical Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Cluses to rinjury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of) physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an page 2 s autopsy performed? 2 ☐ No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Nnpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Maryland 21215-0036 Baltimore, permit. Page Department o Important: If any Injury or Physician Examiner ted be exac Box 68760. that the death certificate P.0. Division or Vital Records, or Attending the Funeral Director: hours after 24 ٥

Medical Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) henell Donadee MD 31. Date filed (Month, Day, Year State

29b. Signature and title of certifier

29a. Certifier

(Check only one)

225. GreeneSt, Baltimore, MD 21201 32. Registrar's Signatu

-endeeMO

AUG 1 3 2007

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

16646

29d. Date signed (Month, Day, Year)

2007

			for State Registrar	State of M	arylan		artment rtificate			ınd M		giene Reg. No.	07	2.7713
44	Physici	an	1. Decedent's Name (First, Middle,			a . 1-					2 Date of De Month	ath Day	Year	3. Time of Death
	/Medic	al	Geraldine 4a. Facility Name (If not institution,	Faye		Crock		Town or	Location of	f Doath	August	6,20	0.7 ty of Death	11:43a M
	Examin	er	Washington A	-	/				na Pa				tgom	
34.	Funeral Director		352-38-4769	6. Sex 7. A	ge (In yrs. 96	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bird (Month, Da 3 / 0 4	h y, Year) /1911		place (State or Foreign intry) inois
	iryland how		Usual Residence of Decedent 10a. State 10b. County MD Monto	OMORY		y, Town or Lo		na						10d. Inside City Limits
	8a-1	ecto		Oller A	21	lver	_					40 000		1 ☐ Yes 2 🔀 No
	3a or 2	II Dir	10e. Street and Number 11621 New Ha	mpshire A	venu	е	10f. Zip	0904	1			10g. Citizen of	r what Cou SA	intry ?
36	be filed within 72 hours after deeth with the Maryland ital Hygiene. d other then "naturel", or iteme 23a or 28a-f ehow event, "he Medical Exerciner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Deceden Armed Forces ad 1 ☐ Yes 2 If Yes, Give ↑ Year or Dates	?		Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	- 14. Ra Bl	ace - Ameri ack, White, ify:	
ည်	72 hou	eted	15. Decedent's (Specify only highest	s Education		16a. Dece	dent's Usua kind of wor DO NOT us	I Occupa	ition luring most	of worki	ng	16b. Kind of	Business/Ir	ndustry
21215-0036	filed within 7 thygiene. other then "rent, "in Med	Completed	Elementary/Secondary (0·12)	College (1-4or	5+)		<i>DO NOT u</i> s ish					Metho	dist	Church
	filled Hygie other	Be Co	17. Father's Name (First, Middle, L			rar	1511	V 1.5.		r's Name	(First, Middle,	·		onar on
ylan		To B	Walter Schma	n					Mami	le E	Eliza I	Decker	, 	
Maryland	s 1 and 2 should of Health and Mer item 27 is marks other traumatic		19a. Informant's Name/Relationshi David Crocker											pcod20782 ark,Md
	s 1 and f Healt item 2 other		20a. Method of Disposition	<u>·</u>	20b. P	Place of Dispo		-			Date	20c. Location		
Ë	Pages ment of ant; If it ury or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation ☐ ☐ Other (Sp	ecify)	C	hesap	eake	Cre	°m. ∤ 8	3/09	/2007	Belt	svil	le,Md.
Baltimore,	permit. Pages 1 Department of H Important; If Itel any Injury or ott		21. Signature of An ral Service L	201										E,P.A.
	Physician /Medical		23a. Part1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	only one cause on each	RIUS	LLENO					vd.Si.		i	Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed to the law requires that has been signed by the attending physicien and age 2 should be detached for use as the burial-transit of	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or a c. — Due to (or a d. —										
.O. Box 6	at the death certific by the attending p tached for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	I death 3	⊒Ectopic pro □ Other (sp						ate of delive	very Day Year
٦.	w requires that been signed b should be deta	Completed by Pl	Part II. Other significant condition	SEM ONT A		ulting in the U			on in Part I.		23e. Did t			the cause of death?
eco	law ren as bee	plet	THRIVE, HY	PERLIEWSI	WN,	ATT	LIM	FI	3211	UATI	24a. Was	DSY	. Were aut	opsy findings available ompletion of cause of
<u>8</u>	rsician: The law s certificate has l director, page 2 s			MULTI WE A	MN,	IMM	y D	1547			1 ☐ Yes	rmed? 2⊞ No	death?	2 No
\rightarrow	ysiciar is cartif directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	tient 2 1	ER/Outpatie	nt 3 🗆 DO	A Oth	-		n <i>(Check only o</i> me 5 ☐ Resi		ther (Spec	ifv)
Division of Vital Records,	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investig:	28a. Date of In (Month, D		28b. Time o		8c. Injun			28d. Describe			
DIVIS	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	Certification;	3 Suicide 6 Could no determine	ned 289. Place of I	njury - At ho etc. (Specif	ome, farm, st	reet, factory	r, office			28f. Location (City or To		nber or Rui	ral Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical C	29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the best examiner: On the basis and manner:	of examina	wledge, dear tion and/or in	th occurred ivestigation,	at the tim , in my or	ne, date and pinion, deat	d place, th occurr	and due to the red at the time,	cause(s) and r date and place	nanner as a, and due	stated. to the cause(s)
)	To th Within To th compl	Me	29b. Signature and title of certifier N. Swyan	rsundar	,			05	336				1071	2007
_	(3)		30. Name and address of person v	GIAAVEN	NE, I	SUINE:	Print) 117	SIL	YAM	SUN	inh, 1	10:20	902	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 3 2007	Signary 32. Regis	trar's Signa	out								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Cox Evelyn 11:50 AM 2007 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death
Anne Arundel **Examiner** Anne Arundel Medical Center Annapolis 7. Age (In yrs. last birthday)

85 Yrs. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Aug 21) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 M 2 T F 136-22-5215 North Carolina 1921 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1⊈ Yes 2 □ No Director Prince George's Md Camp Springs 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20748 U.S.A. 6807 Tall Oak Drive Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 No Specify. þ Specify: 3₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Health and Mental Hygiene. Home Maker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Johnson Marrow Margaret Mitchell ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rachel Holloman/Daughter 6807 Tall Oak Drive Camp Springs, Maryland 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important; If ite
any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery: 8/11/2007 | Brentwood, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ been si Completed 1 🗌 Yes 2☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has I rector, page 2 s autopsy 1□ Yes 24100 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manny of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 No 2 Accident Director: 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D16376

State Registrar

DHMH 17 Rev 1/2001

2001 medical Pkwy

32. Registrar's Signatur

Anapolis, MD 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph A Moser ND

e filed (Month, Day, Year AUG 1 3 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 10a, b, c, e, f, 26 per inf dr. , 880, 06/27/08dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Canne 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Wiconico 8511 Engle Street If Under 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 1□M 2\F Months Hours Yrs Director 84 7-5-1923 486-20-6819 Missouri Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event than "at a result of the standard of the sta 10c. City, Town or Location Festus 10d. Inside City Limits 10b. County Jefferson MΩ 1 ☐ Yes 2X No **Wicomico** Funeral Director MD-Delmar 1010558 GTen Oaks Drive 10f. Zip Code 10g. Citizen of What Country? ₂₁₈₇₅ 63028-3134 8511 Engle Street USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Business Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Maness Clara Daugherty 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta Wilkins -daughter Engle Street, Delmar, MD 21875 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) National Cemetery 8-20-2007 Jeffers Baracks, MO 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bounds Funeral Home E. Main Street, Salisbury, MD 21804 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or conshock, or heart failure. List of cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown s been signed by should be detailed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ş 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a Was an page 2 this certificate Yes 2 No Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Daughter's Other: 4 Nursing Home 5 Hesidence 6 Nother (Specify) Home 1 ☐ Yes > No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After or Attending Natural Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. after death filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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1°5 2007

registrar's Signaty

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** 34 M 00 /Medical County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner CE 5 15 UNY OICE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex Social Security Number Age (In yrs. last birthday) 07991304y1927 **Funeral** Days Months Hours 1 M 2 XF 80 301-20-1617 Director Ohio Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 √ Yes 2 No Maryland Director Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or 21804 USA 1101 S. Schumaker Dr., Unit 202 ms 23a o 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 7 Is marked other than "natural", or items traumatic event, the Medical Examiner m. 11 Marital Status Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene.

Is marked other than "natural", or ite 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify Specify: white 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Administrative Clerk Security Trust 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be 1 Health and Mental Anne Ruth Miller George Belville Risher 10 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Theodore L. Childs/husband 1101 S. Schumaker Dr., Unit202, Salisbury, MD21804 of Health Item 27 I 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition Department of Important: If It any Injury or o once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Salisbury Crematory 8/9/07 Salisbury, MD 4 □ Donation 5 □ Other (Specify) squature of Funeral Service Licensee 22. Name and Address of Facility HOLLOWAY Funeral Home Professional Association CFSP 501 Snow Hill Rd., Salisbury, MD 21804 lance Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Netostatil Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 pion 3 Ectopic pregnancy Month for Year months? 4☐ Pregnant at time of death 9☐ Unknown 5 ☐ Other (specify) signed by the a Division or Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy perform death? 25. Was case referred to medical examiner? 26. Place of Death (Check only one director Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day 1 Natural
2 Accident 5 Pending investigation 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce tifie

(Nord

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of

Oceall

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Poester

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:00 PM 2007 14 W. Cross August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Kline Hospice House Mount Airy If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 09-11-1949 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F 57 505-60-2968 Nebraska Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐Yes 2☐No notified Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 21703 6240 Darlington Ct. USA Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or items 23 may or other traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 ☐
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☑ Married 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Defense Cartographer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Garland Cross Ruth Box 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other trau Marjorie L. Cross - Wife 6240 Darlington Ct, Frederick, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery 108-18-2007 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Home, P.A. 21. Signature of Funery Service Licenses 60 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Amystrophic

Due to (o as a conse uence of): lateral sclerosis TYEARS **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ned by the a detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Respiratory 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No s after death.

I Director: After this d in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled i 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ASSOCIATE PROF NEUROLOGY MD 42763 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDREA CORSE NO MEYER 5-119 600 NORTH WOLFE STREET BALTIMORE MARGLAND 21287

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

AUG 1 6 2007

State Registrar

341VA

ND;

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

NDEL

32. Registrar's Signature

HRIS TOPHER

AUG 1 5

31. Date filed (Month, Day, Year)

0031154

III W. HIGH ST #202; Elkton, and

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- For State Amend 10e-f,19b, per Inf, g871, 9/6/07 Certificate of Death

Red. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Gerald W Caple 10 /Medical 2007 11:20 ugust 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAINT AGNES BALTIMORE Under 1 Year | If Under 24 HOSPITAL 5. Social Security Number 6. Sex Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 F Months Hours 83 Director Jan 23, 1924 Maryland 212**-**20-7077 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2KINo **Funeral Director** MD Halethorpe Baltimore 10f. Zip Code **21227** 10e. Street and Number 4606 10g. Citizen of What Country? 4602 Linden Ave United States 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: WWTT Race - American Indian Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: þ Specify: White 3 Widowed 4 Divorced WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) John G. Hetzell & Sheet Metal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, William W. Caple Laura Amelia Brauning 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4002 Linden Ave. Halethorpe, MD 21227 19a. Informant's Name/Relationship (Type. Print) Ferne Caple (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Providence Cemetery 8/13/2007 Gamber, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burrier-Open Funeral Home and Crematory, 1212 W. Old Liberty Rd. Winfield, MD 2178 and/ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Cerebro vascular accident days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last abjal paroxysmal Examiner or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of). ivision or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Congestive hairt Failure Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an this certificate har autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

WALLIAM GER ALD

10+1VA

State Registrar

Norcesa Mohammed 31. Date filed (Month, Day, Year) AUG 1 3 2007

29b. Signature and title of certifier

MO

D0064762

29c. License number

29d. Date signed (Month, Day, Year) August 10, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 South Glon Avenue Baltimore MD 21229

3. Registrar's Signature

			For State	State	of Marylan				ealth a Death	ind M		giene Reg. No. 🥬	7 17 *)	0775
1/2			Registrar Decedent's Name (First, Middle, Last	t)							2. Date of Dea Month		Year	3. Time of Death
	Physicia /Medic		Mercedes Chav								August	10	2007	3:00 ам
	Examin	er	4a. Facility Name (If not institution, give		ımber)		4b. City,		Location o	f Death		4c. Coun	y of Death Montgo	
	<u>*-</u>		Montgomery General 5. Social Security Number 6. S		7. Age (In yrs.	last birthday)		r 1 Year	Olney If Under 2		8. Date of Birth (Month, Day	h ,, , ,	9. Birth	place (State or Foreign
	Funeral Director			□M 2 ⊠ F	88	Yrs.	Months	Days	Hours	Min.	November	13,1918	Pe	eru
	pu ,		Usual Residence of Decedent		10c Cit	y, Town or Lo	cation							10d. Inside City Limits
	anylan show ed at	5	10a. State 10b. County		100. 010	y, 104411 01 Lo	oation						ļ	1 □Yes 2 No
	the M 28a-f notifie	Director	Maryland Montg 10e. Street and Number	omery			10f. Zi		lver S	pring		10g. Citizen o	What Cou	intry?
	3a or		3500 Pear Tree C	ourt, #2	4				20906				U.S.A	A.
	death	Funeral	11. Marital Status		cedent Ever in U.	S. 13. V	Vas Dece	dent of Hi	ispanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)		ace - Ameri ack, White,	can Indian, , etc.
õ	after or ite		1 Never Married 2 Married	1 ☐ Yes If Yes, G	2⊠ No live		ĭ ⊠ Yes	_	Specify:	Peru		Spec	itu	ite
0500-c1	hours tural"; al Exe	d by	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or	Dates:	16a. Deced	dent's Usu	ial Occup	ation	reru	VIAII	16b. Kind of		
<u>.</u>	in 72 n "nat Medica	Completed	(Specify only highest gra	de completea	(1-4or 5+)	(Give	kind of w	ork done d	during mos	t of work	ing			
7 7	d with giene ir thau	E	12	College	(1-401 3+)		Home	naker				(Own Hor	me
Maryiand 21	al Hy d othe	Be	17. Father's Name (First, Middle, Last,						18. Mothe		e (First, Middle,	Maiden Surna	ame)	
Z	ould by Meni	유	Jose Agreda	T D'		10h Mailie	- A d d s o o	o /Straat	and Numbe		La Casana ral Route Numbe	or City or Tow	n State Zi	in Code)
<u>a</u>	d 2 sh th and 7 is n traum		19a. Informant's Name/Relationship (1					aithersbu			
Б	ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at		Jose L. Chavez - S 20a. Method of Disposition			Place of Dispo	sition (Na	me of	1		Date	20c. Location		
ē	Pages nent of I int: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		n State	te of He	•		- 1	8/18	/2007	Silver	Spring	, Maryland
aitimore,	permit. Pages Department of Important: If It any Injury or o	li	21. Signature of Funeral Service Lice	1		22	Name a	nd Addre	ss of Facili	ty	Homo Inc			
מ	88 1 2 8		King	بىلايىر	wow.								ng, Mar	ryland 20904
			23a. Part1. Enter the disease, or com shock or heart failure. List only	plications that one cause on	caused the deat each line.	h. Do not ent	er the mo	de of dyir	ng, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a1	to ne	100	STV	VC	10	27				
	Examiner			Due t	o (or as a consec		Pa	MI	el	-				
Ġ,		ē	Secuentially list conditions. if any, leading to immediate	b. Due t	o (or as a conseq	perice of).			ner	<u> </u>				
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	VIII		- (ar	116-6	V				
Ö,	be executed sician and burial-transit		resulting in death) Last	Due t	o (or as a consec	quence of):								
8760,	ate the	dical		_ d	· · ·									
9 X	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome pf pregn							23d. I	Date of deli	ivery
Вох	death e atter d for u	iciar	in the past 12 months?	4□Pre	e birth 2□Feta gnant at time of c		⊒Ectopic ⊒Other (:		y 				Month	Day Year
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s,	uires that the de signed by the a Id be detached f	by P	Part II. Other significant conditions	contributing to	death but not res	sulting in the u	inderlying	cause giv	en in Part I	l.				the cause of death? obably 4 ⊠Unknown
ord	w requir been s	ted	piaco	Cea										
Sec.	has b	Completed									24a. Was auto perfe		prior to death?	topsy findings available completion of cause of
Vital Records, P.	n: Th ficate or, pag		25. Was case referred to medical						26 Place	a of Daa	1 ☐ Yes	2 X No	1 □ Yes	2□ No
5	Physician: The la rthis certificate has ral director, page 2	o Be	examiner? 1 Yes 2 No	Hospital: 1	Inpatient 2 □] ER/Outpatie	nt 3 🗀 🛭	OA Oth	201:		ome 5□Res		Other (Spec	cify)
0	ding Phy I. After this funeral o	n: To	27. Manner of Death 1 ☒ Natural 5 ☐ Pending		te of Injury onth, Day Year)	28b. Time o	of	28c. Inju Wo	ry at rk?		28d. Describe	how injury occ	curred	
20	endin sath. or: Af he fur	atio	2 ☐ Accident investigation	n .			М	1 🗆	Yes 2	No				
Division or	or Attencafter death Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	20e. F16	ice of injury - At h ilding, etc. (Spec	iome, farm, st <i>ify)</i>	reet, facto	ory, office			28f. Location (City or To	(Street and Nu wn, State)	mber or Ru	ural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 CertifyIng P	hysician: To	the best of my kn	owledge, dea	th occurre	d at the ti	ime, date a	nd place	, and due to the	cause(s) and	manner as	s stated.
	e Hos 1 24 h ie Fun	Medical	(Check only 2 Medical Exa	miner: On the	basis of examin anner stated.	ation and/or in	nvestigati	on, in my	opinion, de	ath occu	irred at the time	, date and pla	ce, and due	e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				2	9c. Licens	se number	20		29d. Date sig	ned (Mont	h, Day, Year)
	3.							Uli	876	0_		08/	10/	10-1
	B		30. Name and address of person who	completed ca	ause of death (Ite	m 23a) (Type	Print)	m	Heath	er Ny	e Lorenzo	, M.D.	b.	20022
		ato	31_Date filed (Menth Party Year)	32	. Revistrar's for	MI	g	y		1	VICE	1 1-1		20832
	SI Regist	ate	AUG 1 5 ZUU/	seem	N. M									

		•	For State Registrar			of Marylan		artmen tificati				ı	Reg. No	-001	27727
Н	Physicia	an l	1. Decedent's Name (First, Mi									2. Date of De Month	Da		
	/Medic		LULA		AVILLE			Ab Cibe	Taum 01	Location of	of Dooth	August		200	
	Examin	er	4a. Facility Name (If not institu	_			700400							-	Georges
			Ft. Washingto 5. Social Security Number	n He		7. Age (In yrs.		If Under	1 Year	ningt If Under		8. Date of Birt			
	Funeral Director		246-42-6941		☐M 2 📆 F	78	Yrs.	Months	Days	Hours	Min.	Feb. 21	y, Year	929 No:	Birthplace (State or Foreign Country) rth Carolina
	ט		Usual Residence of Decedent												10d. Inside City Limits
	arylar show	_	10a. State 10b. Cou	•			ty, Town or Lo								1 ☐ Yes 2X No
	188-1	ecto		ce G	eorges	F'1	t. Wash	11ngt					10a C	itizen of What	
	with t	吉	10e. Street and Number 12021 Livings	ton	DA			101. ZIP	207	1.1.			iog. o	USA	oodiniy.
	within 72 hours after death with the Maryland ons. Then "natural", or Items 23s or 28s-f show fre Modical Exar ilrert ast be notified at	Funeral Director	11. Marital Status	LOII		edent Ever in U	I.S. 13.1	Was Dece			igin? (Sp	ecify Yes or No Rican, etc.)	-	14. Race - A	merican Indian,
(0	r Iten	F	1 ☐ Never Married 2 ☐ N	Married	Armed Fo	orces? 2187 No						Rican, etc.)		Black, W	hite, etc.
93	al', o	Ď	3 Widowed 4 Divor	bec	If Yes, Gi Year or D			1 🗆 Yes	2LAINO	Specify:				Specify:	Black
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N	filed v Hygie Sther t	S	12th 17. Father's Name (First, Midd	de (ast)			Envi	onme	ntai			S L (First, Middle,			Bulluling
anc	ould be f Mental h arked of etic eva	Be c	Kirk Jenkins							Ann	nie B	. Bryar	ıt		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiens and the state of the Marylan strength and Mental Hygiens 7 is marked other then "natural" or items 23a or 28a-1 show other traumetic event. If a Modical Examility is ust be notified at	ဥ	19a. Informant's Name/Relati		Type, Print)		19b. Mailir	ng Address	(Street a			al Route Numb		or Town, State	e, Zip Code)
Ž	nd 2 aith a 27 is		Gloria M. Kno	x/Da	ughter		29692	01d	Cre	ek La	ne	Eastor	1, M	D. 216	01
J.e.	ss 1 a of Hear item		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremati	2	Domaral from	20b. I	Place of Dispo cemetery, crei	sition (Nar	ne of ther plac	e)	ľ	Date	20c. l	Location - City	or Town, State
Ĕ	Page mant g ant: If ury or		`4 □ Donation 5 □ Othe			Me	tropol:	itan_	Crem	atory	8-1	8-07	A1e	exandri	a, VA.
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra once.		21. Signature of Funeral Serv	rice Licer	1588	10	Ma Ma	. Name ar	d Address	s of Facili Fune	ra1	Home,]	Inc.		
_	E 2 2 2		p. 1/1	100	rena							Washing		, DC 2	
0			23a. Page. Enter the disease shock, or heert failure.	, or com List only	one cause on	each line.	tn. Do not ent	er the mod	e of cryin	g, sucn as	cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
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	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1	C.										
oʻ	exac an an rial-tr	Exa	resulting in death) Last	1		(or as a consec	quence of):								
8760,	cata ba exacuted physician and the burial-transit	lical			_ d				_		_				
9	law requires that the death cartificate be exacuted as feen signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:		220 Hugs o	stoome of erean	2501			-0				22d Date of	dolivon
Вох	that the death certific ad by the attending p detached for use as	lan	23b. Was decedent pregnant in the past 12 months?	1	1 Live	utcome of pregn birth 2 Feten nant at time of c	el death 3	☐Ectopic p		,			1	23d. Date of Month	Day Year
	the de	ysic	1 □ Yes 2 ②No 9 □ Unknown	İ	9□Unkr		304111 31	_ Othor (9)							
, P.O	that tad by data		Part II. Other significant con	ditions o	contributing to	death but not res	sulting in the u	nderlying o	ause giv	en in Part	I.	23e. Did 1	tobacco	use contribut	e to the cause of death?
rds	w requires that heen signed to hould be detail	g p	Seizure Disor	der								1 🗆	Yes	2 □ No 3 □	Probably 4 \sumbule Unknown
000	law re	plet	Dementia									24a. Was		24b. Were	autopsy findings available to completion of cause of
of Vital Records,	sicien: The lav certificate has iractor, page 2	Completed by	Elevated Chol	este	ero1							perfo 1 ∐ Yes	ormed? 2⊠N		h? Yes 2□ No
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× ×	Physicien: rthis certific ral diractor,	၉	1 ☐ Yes 2 ☒ No				ER/Outpatier				ursing Ho	ome 5 Resi			Specify)
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Division	Attending r death. sctor: Aftel by the fune	Certification;	3 Suicide 6 □Co	estigatio	e 29a Plac	e of Injury - At h	nome, farm, st								r Rural Route Number,
Οį	after Dira	erti	4 🗍 Homicide	bernimed	build	ding, etc. (Speci	ily)					City or To	wπ, Sta	16)	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific; complately filled in by the funeral director.	alc	29a. Certifier 1☑ Cert	ifying Pl	nysicien: To th	e best of my kn	owledge, deat	h occurred	at the tin	ne, date a	nd place,	and due to the	cause	(s) and manne	r as stated.
-	the Ho the Fu the Fu	edical	(Check only 2 Med one)	icai Exei	and mai	nner stated.	ation and/or in				atti occui	red at the time,			due to the cause(s)
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	7		30. Name and address of per												
	Sta	to	Richard Farson 31. Date filed (Month, Day, Y		21 Living	ston Rd. Registrar's Sign	Ft. Wash	ningta	, Md.	2074	44				
	Registi		31. Date filed (Month, Day, Y	007	Serus	A.	Boards	d					·-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 0 200 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SDU DICOR 11 100 COO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🗓 F 526-54-8634 65 5-12-1942 <u>Arkansas</u> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 K Yes 2 □ No MD Wicomico Salisbury 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 608 W. Isabella Street 21801 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 🂢 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator 6 Bar & Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Warren W. Bennett Ruth M. Bradley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Stuck - daughter Isabella Street, Salisbury, Maryland 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 8-14-2007 Delmar, Delaware 21. Signature of Funeral Service 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CARCINDMA MALIGNANT OF LUNG disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) 23d. Date of delivery Month Day Year tobacco use contribute to the cause of death? Yes 2 □ No 3 probably 4 □Unknown s an

Physician /Medical Examine

death certificate be executed

P.O. Box 68760.

Division or Vital Records,

permit. Pages 1
Department of H
Important: If ite
any injury or ot

Physician

/Medical

Examiner

Director

by Funeral

Completed

Be

2

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

3altimore, Maryland 21215-0036

Examine signed by the attending physician and if be detached for use as the burial-transit Completed by Physician/Medical page Be 2 Certification:

has

certificate

After this

within 24 hours after death

To the Funeral Director:,
completely filled in by the f

ö Hospital

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ★ No 9 □ Unknowh	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic preg 5 □ Other (spec		
Part II. Other significant condition	s contributing to death but not resulting in	the underlying cau	se given in Part I.	23e. Did
				1 🗆
				24a. Wa
				aut per 1∐ Yes
25. Was case referred to medical			26. Place of De	ath (Check only
examiner? 1 ⊟ Yes 2⊒⊅No	Hospital: Impatient 2 ER/Out	oatient 3 DOA	Other: 4 Nursing H	Home 5 ☐ Re
27. Manner of Death	28a. Date of Injury 28b. Ti	me of 28c	. Injury at Work?	28d. Describe

(Month, Day Year)

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No opsy idence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)	V
	_

Natural

3 ☐ Suicide

2 ☐ Accident

4 ☐ Homicide

erifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

M

29b. Signature and title of cortifier

29c. License number 20058410

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

P. DOX 1737, SALISBURY us 21202

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HUCAM WARRIS COASTAL HOSPICE

Registrar

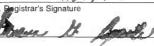
Medical

31. Date filed (Month, Day, Year) AUG 13 2007

5 Pending

investigation

6 Could not be determined



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** DARNELL FLORENCE G. AUGUST 5, 2007 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HAVEN HOMES GROUP HOME POTOMAC If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours 1□M 2₹F Yrs MARYLAND 577-01-9662 AUGUST 28,1912 Director 94 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show "natural", or Items 23a or 28a-f shov idical Examiner must be notified at 1 ☐ Yes 2 No POTOMAC Director MONTGOMERY MARYLAND. 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 20854 U.S.A. 11834 GOYA DRIVE Funeral . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: WHITE Completed by 3 Nidowed 4 Divorced Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANN JOHNSTON 2 THOMAS M. GALLOWAY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8201 PLUM CREEK DRIVE, GAITHERSBURG, MARYLAND 20882 HERBERT DARNELL - SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 □Removal from State 4 □ Donation 5 □ Other (Specify) FORT LINCOLN CEMETERY 8/8/2007 BRENTWOOD, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MARYLAND 20904 23a. Part1. Enter the disease, of complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** UROSEPSIS /Medical Due to (or as a consequence of): Examiner DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician Physician/Medical the attending properties for use as as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed? Yes 2 No 2 No 1 ☐ Yes director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Group Home Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 🖾 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours after To the Funeral Dir (X) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar (Check only one)

29b. Signature and title di certifier

ANUSHIRAVAN DADGAR, M.D., 9715 MEDICAL CENTER DRIVE, #201, ROCKVILLE, MARYLAND 20850 31. Dete filed (Month, Day, Year) AUG 1 5 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

H0051280

29d. Date signed (Month, Day, Year)

AUGUST 6, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 08 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1⊠M 2□F Months 72 25, 1935 Washington, D.C. 578-44-7529 Director Usual Residence of Decedent with the Maryland 10d. Inside Cify Limits 10c, City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ▼Yes 2 No Director MD Prince George's Mitchellville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20721 U.S. 1312 Kings Heather Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give 1957-78 Year or Dates: 1 Never Married 2X Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify þ 3 ☐ Widowed 4 ☐ Divorced American Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Bus Operator WMATA 5 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Joseph Linwood Drew Grace Ridgeley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1312 Kings Heather Dr., Mitchellville, MD 20721 Merla M. Drew / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 ☐Removal from State Aug. 29, 2007 Arlington, VA acility McGuire Funeral Service, Inc. 4 Donation 5 Other (Specify) Arlington Nat. Cem. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 7400 Georgia Ave., N.W. Washington, D.C. hou 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of MULTIPLE MYELOMA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the a 9□Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 □ No 1 Yes 2 No 1 ☐ Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 Tyes 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury 27. Manner of leat 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. after death

Hospital or Attending Physician:

filled in by the To the Hospital within 24 hours at to the Funeral E To the Fund

State

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title

6 □ Could not be

determined

3 ☐ Suicide

29a. Certifier

4 Homicide

29c, License number
29d, Date signed (Month, Day, Year)
29d, Date signed (Month, Day, Year)
29d, Date signed (Month, Day, Year)
8/10/07

29d, Date signed (Month, Day, Year)
8/10/07

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Department of Health and Mental Hygiene. Important: If item 27 is marked other tt injury or other traumatic event, the Med To Re Comm		Jasmine Dupre	ee/Daugh	ter		River				ie, Md	. 207	721
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DUPLICATE

			For State Registrar	State of Maryl		artment of He rtificate of D			iene eg. No. 2	107	27732
			Decedent's Name (First, Middle, Last))		//		2. Date of Deat Month		Year	3. Time of Death
	Physicia /Medic		MATTIE			EASO	NC	AUGUST		2007	06:22 M
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or L			4c. Cour	nty of Death	
	8		5. Social Security Number 6. Se		vrs. last birthday)	BALTIMO	RE CIT	8. Date of Birth		9. Birthi	place (State or Foreign
	Funeral Director			²	Yrs.	Months Days	Hours Min.	(Month, Day, 01/29/19	Year)	Virg	ntry)
1	D		Usual Residence of Decedent		0: 7			01,25,15			
	arylar show d at	_	10a. State 10b. County D.C.		City, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M 28a-f hotifie	Director	10e. Street and Number		мазшици.	10f. Zip Code		14	0g. Citizen o	of What Cou	Λ
	Mith Ba or		1420 F Street, N.E.			20003			U.S		iny.
	ms 2:	Funeral	11. Marital Status	12. Was Decedent Ever i	n U.S. 13.	Was Decedent of Hisp	panic Origin? (Sp	ecify Yes or No-	14. R	ace - Ameri	
350	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	ρ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ∰ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1		Specify:	Hican, etc.)		lack, White,	
5-0036	72 hou natura lica E	Completed	15. Decedent's Edu (Specify only highest grad		16a. Deced	dent's Usual Occupat	ion vina most of work	ring .	16b. Kind of	Business/Ir	ndustry
Z	ithin 7 ne. Med	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	i _	kind of work done du DO NOT use retired)	ing most of work	ang	Forlar	al Gove	ammat
7	lled w Hygier her th		17. Father's Name (First, Middle, Last)	ı year	AO	minstration	I Mather's Name	e (First, Middle, M			IIII EIL
Maryland	d be fi	o Be	Fenton Coston			'		ne Ridley	vialderi Surri	amej	
<u> </u>	shoulk nd Me mark matk	۲	19a. Informant's Name/Relationship (T	/pe. Print)	19b. Mailir	ng Address (Street an			r, City or Tou	vn, State, Zi	p Code)
	nd 2 salth ar 27 is 27 is ir trau		Gene E. Eason - Son		1	Landover Str			-		,
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	b. Place of Dispo cemetery, cres)	Date	20c. Locatio	n - City or T	own, State /aryland
Baltil	permit. Popartm Importar any Injur		21. Signature of Funeral Service Licens		\	2. Name and Address	TITE	eenan Fune	ral S _T	vices	-
۰			23a. Part1. Enter the disease, or comp	lications that caused the						20740	Approximate Interval Between
	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition		04 444	PERTENS	100				Onset and Death
	/Medical		resulting in death)	Due to (or as a cor		EKT CIVS	1074				8 years
	Examiner		Sequentially list conditions	b. SARCOLD							15 years
in.	sit ad	iner	Sequentially list conditions, if any least of the cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	isequence of):						•
	xecut and Il-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a cor	sequence of);						
28/60	ficate be executed physician and s the burial-transit			,	. ,						
200		edical		α							
). Box	The law requires that the death certific: tre has been signed by the attending pl bage 2 should be detached for use as t	Physician/M	in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome pf pr 1□Live birth 2□ 4□Pregnant at time 9□Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			- 1	Date of deliv Month	very Day Year
J.	w requires that the dibeen signed by the should be detached	Phy	9 ☐ Unknown Part II. Other significant conditions co	VIO.2-200-2-2-2-2-2-2-2-2-2-2-2-2-2-2-2-2-2	reculting in the u	nderlying cause giver	n in Part (23e Did to	hacco use o	ontribute to	the cause of death?
ď,	ires ti signe d be d	by	Part II. Other significant conditions of	minutaling to death but not	resulting in the u	indentying cause giver	THIT CIT.	1 □ Y			obably 4 □Unknown
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Vital R			25. Was case referred to medical				26 Place of Deat	1 Yes th (Check only on	2X No	1 🗌 Yes	2□ No
	hysicis this cer	o Be	evaminer?	Hospital: 1X Inpatient	2 ER/Outpatier	Othor		ome 5 Reside	,	Other (Spec	ify)
n 0	ding Ph J. After th funeral	T:U	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o	f 28c. Injury Works		28d. Describe h			
Division	tendir leath. tor: Ai the fu	Certification:	2 Accident investigation			M 1□Y	es 2□No				
Š	or Att	rtific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - building, etc. (S	At home, farm, str pec <i>ify)</i>	reet, factory, office		28f. Location (S. City or Town		mber or Ru	ral Route Number,
	To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical Ce		ysician: To the best of my liner: On the basis of exa							
	o the inthin (o the omple	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number	2	29d. Date sig	ned (Month	i, Day, Year)
)	r × + ŏ		1-7-7	MEO	ICAL DOCT	OR RES	-000				9,2007
1	(6)		30. Name and address of person who of	completed cause of death	(Item 23a) (Type,	Print)					21237
	Sta Registi		31 Date filed (Month Day Year)	32. Registrar's S	Signature	1,7,5	1.4 200 27 18		. 13521	, -, -, -,	a car of landers
				- rear in /							

07-05993 Joseph Eborn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Spii Lboii.		For State	Certificate	of Death	Reg. N	
Physician	1 1.	Decedent's Name (First, Middle,Last) Joseph Eborn			2. Date of Death Month Da August 5, 200	3. Time of Death 0058 hrs
Examin		a. Facility Name (if not institution, give street and numl	per)	4b. City, Town, or Location of I		4c. County of Death Prince George's
Funeral Director	5	. 555	Age (In yrs. last birthday)		24Hrs. 8. Date of Birth(N	MM/DD/YYYY) 9. Birthplace (State or ForeignWashington Country) D. C.
		Usual Residence of Decedent	10c. City, Town or Lo	cation	1105.	10d. Inside City Limits
ow any		Oa. State 10b. County Maryland Prince Georges		Marlboro		1 XYes 2 No
taryland 28a-f st l at onc	Director	0e. Street and Number		10f. Zip Code		Citizen of What Country?
vith the Maryland s 23a or 28a-f show a notified at once.		2703 Box Tree Dr.	dent Ever in U.S. 13.	20772 Was Decedent of Hispanic Origin	n? (Specify Yes or No-	United States 14. Race - American Indian, Black, White, etc.
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland near of Health and Mortal Hygiene. The first and 27 is marked other than "natural", or items 23a or 28a-f she are it item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	Fune	1 Never Married 2 X Married Armed For 1 Yes 3 Widowed 4 Divorced If Yes, Give Year	ces? 2 No	If Yes, specify Cuban, Mexican, Yes 2 X No specify:	Puerto Rican, etc.)	Specify: Black
ours aft	bg bg	15. Decedent's Education (Specify only highest grade	dunir	edent's Usual Occupation (Give king most of working life, DO NOT u		6b. Kind of Business/Industry
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2121 2121 ould be fi Mental marked ic event,	o Be	Joseph Synder 19a. Informant's Name/Relationship (Type, Print)		ailing Address (Street and Num	ber or Rural Route Number	er, City or Town, State, Zip Code)
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Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumat		20a. Method of Disposition 1	m State crematory	or other place) ony Memorial		Landover, Md.
Saltir ermit. I Departmo mporta njury o	1	21. Signature of Funeral Servi Licensee	1100	22. Name and Address of Facility Alexander S. 5538 Marlbord	Pope Pikė/Fores	stville, Md. 20747
hysician	+	23. File Enter the dilease, or complications that ca failure. List only one cause on each line.	aused the death. Do not en	nter the mode of dying, such as co	ardiac or respiratory arres	st, shock, or heart Approximate Interval Between Onset and Death
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ted 1 insit	Exan	events resulting in death) Last Due to (or as a	consequence of):			
760, cate be executed physician and he burial - transit	Medical	UNPENDED AMENDED				23d. Date of delivery
က ခွ် ခွ် ည	sician/Me	23b. Was decedent pregnant in the past 12 months? 1 Live 4 Preg	outcome of pregnancy birth 2 nant at time of death 5	Fetal death 3 Ectopi	ic pregnancy	Month Day Year
BOX he death the atte	Physi	Part II. Other significant conditions contributing		n the underlying cause given in P		bacco use contribute to the cause of death?
P.O. B es that the d gned by the e detached	5				1Yes	2 No 3 Probably 4 Unknown
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Functural Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Completed					prior to completion of cause of death?
tal Rection: The la	Som	and the modical		26.Place of Death	1 Yes	2 No 1 Yes 2 No
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n of Vital Recling Physician: The Land After this certificate Pfuneral director, page	n: To	27 Manner of Death 28a, Dat	e of Injury th, Day Year) 28b. Ti 2007 0037	me of Injury 28c. Injury at Wohrs 1 Yes 2	 Driver moto 	how injury occurred rcycle auto collision
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director. completely filled in by the	Certification:	3 Suicide 6 Could not be determined (Specification of the determined (Specification of the determined	Major Road / Hig	hway	14306 Indian	Head Highway, Indian Head, Md.
Di To the Hospital within 24 hours a Fo the Funeral I	Medical	29a. Certifier 1 Certifying Physician: To the b (Check only one) 2 Medical Examiner: On the basi	s of examination and/or in	h occurred at the time, date and prestigation, in my opinion, death	occurred at the time, date	
To the within 2 To the complete	Med	29b. Signature and title of ceruffier	stated.	29c. License number		29d. Date signed (Month, Day, Year) August 5, 2007
18		30. Name and address of person who completed ca	use of death (Item 23a)	1 Penn Street, Baltimore	MD 21201	
1- [4]	3100	Susan Hogan MD. Assistant Med 31. Date filed (Month, Day, Year) 32.	ical Examiner 11 Registrar's Signature	T Penn Sueet, Datamore	,	
Regi	State	410 4 4 0007	1. Soul			

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			For State Registrar		• •		land / Dep		t of H	lealth a	and M	ental Hy	giene Reg. No.		2773 ;
Ą	Physicia /Medic		1. Decedent's Name (A									2. Date of De Month Augus 1	Day	2007	3. Time of Death 2:30am M
	Examin	_	4a. Facility Name (If no Calvert M.						Town, or	Sun	of Death			County of De	eath
*	Funeral Director		5. Social Security Num 222-10-71	96	5. Sex 1 □ M 2√2 F	7. Age (Ir 89	yrs. last birthday Yrs.	/) If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 10/15/	1917	9. E	Birthplace (State or Foreign Country) 1m. DE
	land ow		Usual Residence of De 10a. State 1	ob. County		10	c. City, Town or I	_ocation							10d. Inside City Limits
	e Mary	Director		Harfor	d	F	allston								1 ☐ Yes 24☐ No
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Baltimore, Maryland 21215-0036	"netur	Completed	15 (Specify	5. Decedent's only highest	s Education grade completed		16a. Dec	edent's Usure kind of with DO NOT L	al Occup ork done o	ation during mos	t of workii	ng	16b. Kir	d of Busine	ss/Industry
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nd	be filed tal Hygi d other	Bec	17. Father's Name (Fi		ast)					18. Mothe	ar's Name	(First, Middle	, Maiden :	Sumame)	
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f Vii	di is	To B	examiner?		Hospital: 1	Inpatient	2 ER/Outpat	ent 3□□	OA Oth			me 5 Res		Other (5	Specify)
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Division	r Attenter deat	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could n determi	ot be 28e. Plac	e of Injury ding, etc. (- At home, farm, Specify)			1165 2		28f. Location City or To			r Rural Route Number,
	Hospita 14 hours Funeral	Medical Co	29a. Certifier 1 (Check only 2 one)	Certifying	g Physician: To the Examiner: On the and ma	ne best of n basis of ex nner stated	amination and/or	ath occurred	at the til	me, date ar opinion, dea	nd place, ath occurr	and due to the ed at the time	cause(s) , date and	and manne place, and	r as stated. due to the cause(s)
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			10	J. S.	tas			\	70	028	35	4	8	140	4
	6	8	30. Name and address	s of person v	M N 10	1 (10000	Ω.	Sui	te A	Ris'	ina Si	en W	an a	1911
100 A CO.	Sta Regist	ate rar	31. Date filed (Month)	Day, Year) UG 1	32.	Régistrar's	Signature	fort		1		7	1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Elsie Marie Edwards August 10. 2007 12:10 P.M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Y 7/17/24 5. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Year Min Hours 1 □ M 2 🔀 F 83 Director <u> 216-22-3448</u> Bowie, Md Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or than "natural", or items 23a or 28a-f show the M-dical Examiner must be notified at X Yes 2 No Upper Marlboro P.G. Director Md. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20774 U.S.A. 304 Wren Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married African-Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. Specify: 2 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Health Care Nurse 12th i. Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If Item 27 is marked other t ijury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Inez Edith Winfrey William Oliver Prout, Sr. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte A. Parker/Sister 304 Wren Court, Upper Marlboro, Md. 20774 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once, Chesapeake Crematory, Inc. 8/15/07 Beltsville, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Licenses 1 WG Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Cequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and use as the burial-tra Due to (or as a consequence of): the attending physiciar Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1□Yes 2▼No 9□Unknown detached signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by should be 2 No 1 ☐ Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No page 2 autopsy perform certificate director 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

Box 68760. P.O. or Vital Records, Division

or Attending Physician: death. after death filled in by the Hospital

within 24 hours a

To the Funeral C

completely filled i

State

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12070 DID Line Centre FMAN MD

Registrar

			1 = For State Registrar	State of Maryla		artmei	nt of H			ntal Hy	giene Reg. No.	0.7	27755
	Physici		1. Decedent's Name (First, Middle, Las THELMA	7)	EL	DR	106	E	2	Date of Dea Month		2007	3. Time of Death 1507 PM
	/Medic Examin	or	4a. Facility Name (If not institution, give WASHINGTON ADVE	NTIST HUSPI		TAI	KOM	Location of PA	RK		MOI		MERY
*	Funeral Director		5. Social Security Number 577–56–0323 Usual Residence of Decedent	nx 7. Age (in yi	93 Yrs.	Months		Hours	Min.	Date of Birt (Month, Day 1g. 2,	v. Year)	Cour	place (State or Foreign htry) SSIPPI
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	eath v		1720 Michigan A	ve., N.E. 12. Was Decedent Ever in	U.S. 13	Was Dec		017 Ispanic Orio	in? (Specif	v Yes or No		S.	can Indian.
936	urs after d	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:	0.3.			Specify:	Puerto Ric	y Yes or No- an, etc.)	E	Black, White, Black	etc.
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altimore,	of Hea of Hea fitem: r other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		. Place of Disp cemetery, cre	osition (Na ematory or	ame of other plac	ce)	Dat	8	20c. Location	on - City or To	own, State
Ĕ	permit. Pages Department of Important: If it any injury or o		4 Donation 5 Other (Specify		incoln_			Au	g. 17	, 2007	Sı Sı	uitlan	d, MD
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68760,	/Medical Examiner bhysician and si the burial-transit	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ATHERO S.C. Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons d.	equence of):								
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	(4)		1 Della	n			60	319	7		08	,09,	2007.
	Je		30. Name and address of person who DARCIE H;	AMMER	7600 Ca		l Ave	., Ta	koma	Park,	MD 20	912	
	Sta Registi		31. Date filed (Month, Day, Year) AUG 1 5 2007	32. Registrar's Si	gnature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7 Year Essim **Physician** 22:22 PM pline 0 2007 31 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Cit UMMS If Under 1 Year | if Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, Months Days Hours 1 ☐ M 2 💢 F 18 Cameroon 1967 218-27-0519 40 Jan. Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Y Yes 2 No Burtonsville Director Montgomery Md 10f. Zip Code 20806 10g. Citizen of What Country? 10e. Street and Number 3600 Childress Terrace U.S.A. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Maritai Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Specify: Black 1 ☐ Yes 2 ☑ No 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Registered Nurse 2 vrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Enow Mesark Essim မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3600 Childress Terrace Burtonsville, Maryland 20806 Daniel Essim/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Manyu, Cameroon 8/24/2007 Fotabe Cemetery 4 Donation 5 Dother (Specify) Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear/failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to minimum at cause. Enter Underlying Cause (Disease or injury Dun to (or as a consequence of): Physician/Medical Examiner that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2√No 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2√ No 1 ☐ Yes 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Medical Certification: To

/Medical Examiner The law requires that the death certificate be executed the burial-tran and Division or Vital Records, P.O. Box 68760, as use ō detached the Hospital or Attending Physician: death. d in by the To the Hospius.
within 24 hours after
To the Funeral Dir

Physician

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

30. Name and address of person who completed cause of death (item 23a) (Type, Print) Elizabeth Lamos 22 S. Greene

St. Battimore, mo 21201

29d. Date signed (Month, Day, Year)

08/01/2007

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

AUG 1 4 2007

32. Registrar's Signature

Registrar

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 August 1:58 A] M DeAngelis Follett Helen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Crofton Nursing & Convalescent Ctr. Crofton 8. Date of Birth (Month, Day, Ye Aug. 14, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Year, Months Hours 1 □ M 2 □ XF Mass. 019-10-1456 95 1911 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Crofton Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21114 USA Funeral 23a 1530 Ellsworth Ave. 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any Injury or other traumatic event, the Medical Examines 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carmela Milleflore Angelo DeAngelis ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21114 1530 Ellsworth Ave. Crofton, MD. Menosky / daughter Eleanor 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08/17/2007 Framingham, Mass. 4 □ Donation 5 □ Other (Specify) St. Tarcisius Cem. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Beall Funeral Home 20715 Bowie, MD, 6512 NW Crain Hwy. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscherotic **Physician** ecn /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed Dementio and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 ☐ Probably 2 No 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Hospital: Other: 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 Inpatient Medical Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at ⁴ Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State

Rakesh Arora, M.D. 31. Date filed (Month, Day, Year) AUG 1 4 2007

29b. Signature and title of certifier

14300 Gallant Fox Lane 32. Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

Suite 222

29d. Date signed (Month, Day, Year)

20715

Bowie, MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** FIELDER Ε. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Hospital Center 5. Social Security Number **Funeral** Months 1 M 2 M Director 225-52-1836 66 Usual Residence of Decedent 10c. City, Town or Location a or 28a-f show be notified at 10a. State 10b. County District of Columbia Director Washington 10e. Street and Number 10f. Zip Code 627 - 49th Street, NE 20019

2. Date of Death 3. Time of Death Day Year August 12 2007 10:30 A 4c. County of Death Cheverly

der 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Prince George's March 9, 1941 Louisa, VA 10d. Inside City Limits 1 √Yes 2 No 10g. Citizen of What Country? United States Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 r than "natural", or the Medical Exami 1 ☐ Yes 2 ☐ No Specify. Black. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) d 2 should be filed who and Mental Hygiel 7 is marked other the 12_years Clerk/Casbier Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Johnson Martha Ragland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health ar 627 - 49th Street, NE Washington, DC 20019 Horace Fielder - Husband permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Quantico Nat'l Cemetery Aug. 20, 2007 Triangle, VA -22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Lice 4001 Benning Road, NE Washington, DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Infarction Minutes /Medical Due to (or as a consequence of): **Examiner** Coronary Artery Disease 4 Months Sequentially list conditions, if any, leading to infine lists cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a constrainment of Physician/Medical Examiner The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of) P.O. Box 68760, physician use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Hypertension, Morbid Obesity, Type Two Diabetes 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Diet Controlled autopsy performed? Yes 2 2 40 page 2 certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 Natural 5 Pending investigation hours after death.

Ineral Director: Af

y filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a

To the Funeral I

completely filled 1 Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signate DC 13778 2∞ 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THOMBSA. TESORIERD FLOD PENNSYLVANIA AVENW WASH

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12, 3:15 P. 2007 Goldie Queen Francis August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Prince George's Laurel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 😡 F Cap. Hgts., Md. Director 80 11/15/26 579-30-6907 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County ns 23a or 28a-f show must be notified at MXYes 2 No Director P.G. Md. Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 20706 9885 Greenbelt Road # 322 U.S.A. Completed by Funeral items 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Examiner be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: ō 1 ☐ Yes 2 ☑ No Black 3altimore, Maryland 21215-0036 Specify Specify 3 Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerk U.S. Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Menta Sophia Davage Stephen Queen ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Item 27 I Veronica A. Bryant/Daughter 208 Manor Terr., Landover, Maryland 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 : 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 8/17/07 Landover, Maryland Harmony Mem. Park 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cerebrovascular Accident 1 Day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the IF FEMALE:

23c. If yes, outcome pf pregnancy

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Syed Sadiq, M.D.

1 5 2007

Year)

31 Date filed (Month. Day.

AUG

14333 Laurel

32. Registrar's S

1 Live birth 2 ☐ Fetal death

Certification: To Be Completed by Physician/Medical as use signed by the page 2 s funeral

23b. Was decedent pregnant

The law requires that the death certificate be or Attending Physician; afer death

Director

di by the f To the Hospital within 24 hours a

To the Funeral I

completely filled

1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 ☐ Other (specif	y)			Month Bay Four
Part II. Other significant conditions	s contributing to death but not resulting in t	the underlying cause	e given in Part I.	23e. Did	tobacco us	se contribute to the cause of death?
Chronic Atr	ial Fibrillation		 	1 🗆	Yes 2□	No 3□ Probably 4 Unknown
				24a. Was auto perf 1∐ Yes	opsy ormed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical			26. Place of Death	(Check only	one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ☐ ER/Outp	patient 3 □ DOA	Other: 4 Nursing Hor	me 5□Res	idence 6	Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	ion	jury	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury	occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		m, street, factory, of	fice 2	28f. Location City or To	(Street and own, State)	Number or Rural Route Number,
	Physician: To the best of my knowledge, caminer: On the basis of examination and and manner stated.					
29b. Signature and title of certifier	(A.)	29c. Li	cense number		29d. Date	e signed (Month, Day, Year)

D24721

Bowie Road # 208, Laurel, Maryland 20708

3 ☐ Ectopic pregnancy

23d. Date of delivery

Vear

Month

August 13,2007

State Registrar

Medical

07-06174 Alexander Frank

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1000	. , , , , , , , , , , , , , , , , , , ,			•
	State of Maryland	Department of He	alth and Menta	l Hygiene

examuel Hank		- For State Certificate Certificate	e of Death	Reg. N	o. []	7 - 1 - 1
Physicia	ın/	1. Decedent's Name (First, Middle,Last)		Date of Death Month Da	Year	3. Time of Death 1020 hrs
ledical Exami		Alexander Frank	4b. City, Town, or Location of Deat	August 11, 20	4c. County of Deat	1
		4a. Facility Name (if not institution, give street and number) Super 8 Motel	College Park		Prince Georg	
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		s. 8. Date of Birth(M	M/DD/YYYY) 9. Bi	rthplace (State or
Funeral Director		212-06-3213 1 <u>x</u> M 2 F 25	Yrs. Months Days Hours Mir		Fore	ountry) Maryland
any or the contract		Usual Residence of Decedent 10c. City, Town or 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
*		Maryland Montgomery	Silver Spring			1 Yes 2 X No
laryland 28a-f show 1 at once.	휭	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Co	untry?
ith the Maryland 23a or 28a-f sho notified at once.	Director	1703 East West Highway, #321	20910	- 31	U.S.A	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If Hen 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once	ā	11. Marital Status 12. Was Decedent Ever in U.S. 1	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert		14. Race - Ame White, etc.	rican Indian, Black,
death r iten	Funeral	1 X Never Married 2 Married Armed Forces?	if Yes, specify Cuban, Mexican, Fuert	o Rican, etc.)	wille, etc.	
after al", o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:		Specify:	White
hours		du	cedent's Usual Occupation (Give kind of ring most of working life. DO NOT use re		b. Kind of Business	s/industry
36 in 72 han " lical I	ë	Elementary/Secondary (0-12) College (1-4 or 5+)	Student	41.40	Educat	ion
-00; 1 with giene giene ther ti	Completed	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid		
21215-0036 uld be flied within 72 hours afth Mental Hygiene. marked other than "natural" cevent, the Medical Examine	Bec	William H. Frank	Jan	et L. Mireng	off	
should be filed with and Mental Hygiene. 7 is marked other that it was not a marked other that it was not a marked other than the Med	To	19a. Informant's Name/Relationship (Type, Print)	Mailing Address (Street and Number or	Rural Route Number	, City or Town, Sta	te, Zip Code).
and 2 shou lealth and N ten 27 is n traumatic			9 Westfield Drive, Bet	hesda, Maryl	and 20817 oc. Location - City	an Town Chair
re, ML 11 and 2 s 11 Health a 17 item 27 er traum			Disposition (Name of cemetery, y or other place)	Date 2	oc. Location - City	or rown, state
MOF6 Pages 1 tent of H unt: If i		4 Donation 5 Other Specify: Judean M	Memorial Gardens 8	/14/2007	Olney, Mar	yland
Baltimore, ML permit. Pages I and 2 s Department of Health a Important: If Hem 27 injury or other traum		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Hines-Rinaldi Funeral	Home, Inc.		
00 % Q = .5		23a. Part I. Enter the disease, accomplications that caused the death. Do not	11800 New Hampshire A	venue. Silve	r Spring	Mary1and 20904 Approximate Interval
Physician dical		failure. List only one cause on each line.	enter the mode of dying, such as cardiac		SHOOK, OF HOUSE	Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) Intraoral Gunshot Wound Due to (or as a consequence of):				
•		h				
	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examiner	C. Due to (or as a consequence of):				
ted 1 ansit	Exa	events resulting in death) Last Due to (or as a consequence or). d.				
execu an and al - tra	ical	UNPENDED AMENDED				
A.cords, P.O. Box 68760, Telan requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliv	rery
587 ertifica ding p	an/I	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic preg	nancy	Month	Day Year
Box 687 e death certific the attending p	sici	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)			
D. B the de by the	Phy	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did toba	cco use contribute	to the cause of death?
P.C s that gned a deta	þ			1 Yes	2 🗸 No 3 P	robably 4 Unknown
ds, equire een si ould b	Completed			24a. Was an autopsy		autopsy findings available to completion of cause of
COF lawr has b	혈			performe		?
T. T. e. fificate	ខិ	25. Was case referred to medical	26.Place of Death (Che		NO I	163 2 110
ital sician is cert	B B	examiner? Hospital: 1 Innatient 2 FR/Out	Othor		esidence 6 🗸 Ot	her: Scene
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safer death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	<u>۽</u>	27 Mapper of Death 28a, Date of Injury 28b, T	me of Injury 28c. Injury at Work?	28d. Describe ho		
On C anding ath. r: Af	텵	1 Natural 5 Pending FOUNT Aug 11, 2007 FOUNT 1019		Subject shot s	seir	
riSiC r Atte er dez irecto irecto	fical	28e. Place of Injury - At home, far	m, street, factory, office building, etc.			Rural Route Number, City
Div italo rat Di	Certification:	3 Suicide 6 Could not be determined (Specify) Hotel		or Town, Star Super 8 Motel, (College Park, MI	
Division of Vital Rac To the Hospital or Attending Physician; The L within 24 hours after death. To the Funeral Director: After this certificate b completely filled in by the funeral director, p. ge		29a. Certifier 1 Certifying Physician: To the best of my knowledge, deaf	h occurred at the time, date and place, a	and due to the cause(s) and manner as s	stated.
o the o the ontple	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.				
•	ž	29b. Signature and title of certifier	29c. License number		29d. Date signed (
5		Fatruillrenica-toller	Na O.C.M.E.		August 12, 20	
(3)		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Exami	ner 111 Penn Street, Baltim	ore, MD 21201		
•	tate					
Regis		31 AUG 1 (15" 2007 ear) Server 32. Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 6:40 P M 9, 2007 PEGGY GARNER AUG. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES GENERAL HOSPITAL PRINCE GEORGES CHEVERLY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🗙 F Director 050-28-4968 DEC. 15. **NEW YORK** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28e-f show the Medical Examiner must be notified at 1 XYes 2 ☐ No MD. PRINCE GEORGES UPPER MARLBORO Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14707 BROCK HALL DR. 20772 U.S.A. death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2X No ff Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 XNo Specify: Specify: þ 3 Widowed 4 Divorced BLACK "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 5+ **TEACHER** PUBLIC SCHOOLS permit. Pages 1 and 2 should be life Department of Health and Mental Hy Important: if Item 27 is marked oth any lijury or other traumatic event 90RB. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LEIGH D. McQUEEN MARIAN Ι. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LESLIE GARNER/DAUGHTER 14707 BROCK HALL DR., UPPER MARLBORO, MD. 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 8-11-2007 RIVERDALE, MD. 21. Signature of Funeral Service Licensee CHAMBERS FUNERAL HOME & CREMATORIUM, P. A KULAL M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. fmmediate Cause (Finaf disease or condition resulting in death) FAILURG IRATORY **Physician** /Medical PULMONARY FIBROSIS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine or Attending Physicien: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 Tyes VIJU MONIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 1 patient 2 ER/Outpatient 3 DOA After thi ate of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending Director: A 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29c) icense number 28195 29b. Signature and title of certifier GOOTAY. NO. 1450 MCACANTILE LN. #217. LARGO, MD. 20774 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

Department of H Importent: If Ite any Injury or ot once.

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

Item 27 is marked other than "neturel", or items 23a or other traumetic event, the Medical Examiner must be in

Director

Funeral

ģ

Completed

Be

death with the Maryland

3altimore, Maryland 21215-0036

ed by the s detached f Certification: To Be

Division or Vital Records, P.O. Box 68760.

Immediate Cause (Final disease or condition resulting in death)	a CARDIAL FAILURE		6 hours
Sequentially list conditions,	b. Pue to Pas a consequence of: Failure		48 hours
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of): Due to (or as a consequence of):	IANT NEOD	Asm Nos 12 months
rosoning in death, East	Due to (or as a consequence of): d	19	5.2
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions or	ontributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death?
		24a. Was an autopsy performed2 1∐ Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?	26. Place of Dea	th (Check only one)	
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H	lome 5 K Residence	6 □Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28b. Date of Injury (Month, Day Year) 28b. Time of Injury Injury M 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injur	y occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street an City or Town, State	d Number or Rural Route Number,)
29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best of my knowledge, death occurred at the time, date and place tiner: On the basis of examination and/or investigation, in my opinion, death occurred manner stated.	e, and due to the cause(s) urred at the time, date and	and manner as stated. d place, and due to the cause(s)

29c. License number

60300

29d. Date signed (Month, Day, Year)

ST MICHAELS, MOZIGG3

State Registrar

Medical

AUG 1 0 2007

29b, Signature, and title of certifier

Joseph

31. Date filed (Month, Day, Year)

Besso, IR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TALBUTST. 10135

To the Hospital or Attend within 24 hours after death. To the Funeral Director:

500

			State of Maryland / Depa	artment of Health and Mental F	
			1103101101	rtificate of Death	Reg. No.
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Month	Day Yeer
	/Medic		EVELYN SMITH GEE	AUG	
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			LAYHILL CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	SILVER SPRING If Under 1 Year If Under 24 Hrs. 8. Date of	MONTGOMERY Birth S Birthplace (State or Foreign
	Funeral Director		230 50 5008 1□ M XXF 90 Yrs.	Months Days Hours Min. (Month,	Birth Day, Year) 16, 1916 9. Birthplace (State or Foreign Country) SOUTH CAROLINA
			Usual Residence of Decedent	1000	10, 1910 Booth officering
	nylan how	_ :	10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits
	e Ma	cto	MD MONTGOMERY OLNEY		XXYes 2 □ No
	death with the Maryland me 23a or 28e-f ehow rman be notified at	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	ath w	ra	2952 McGEE WAY	20832	UNITED STATES
		Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.
0000	rs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes X M No If Yes, Give Year or Dates:	1 ☐ Yes 🐰 🕅 No Specify:	Specify: BLACK
ş	within 72 hours atter death with the Marylan ene. than "natural", or iteme 23s or 28e-1 ehow ha Madical Exandrater must be notified at		15. Decedent's Education 16a. Dece	dent's Usual Dccupation	16b. Kind of Business/Industry
2		Completed	(Specify only highest grade completed) (Give life.	kind of work done during most of working DO NOT use retired)	
7	e filed with Il Hygiene other the	ĕ		JSEKEEPER	PRIVATE
and	al Hygi I other	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mic	ldle, Maiden Surname)
<u>a</u>	should be nd Mental r marked umatic ev	To	WILLIE SMITH	BERTHA LAW	N.
<u>a</u>	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me	8 8		ng Address (Street and Number or Rural Route Nu	mber, City or Town, State, Zip Code)
≤ o`	s 1 and if Health Item 27 other ti			McGEE WAY OLNEY, MI	
<u> </u>			1XXBurial 2 □ Cremation 3 □ Removal from State cemetery, cres	matory or other place)	20c. Location - City or Town, State
	프 든 은 글	1		ONAL CEMETERY 08/14/200	
Ö	permi Depa Impo eny ir		T. Henall	2. Name and Address of Facility IARSHALL'S FUNERAL HOME 1308 SUITLAND ROAD SUIT	OF MARYLAND, INC. FLAND, MD 20746
			23a, Part Enter the disease, or complications that caused the death. Do not en		
	Physician		shook, or heart failure. List only one cause on each line. Immediate Cause (Final		Onset and Death
	/Medical		disease or condition resulting in death) a. DEMENTIA Due to (or as a consequence of):		
	Examiner		Sequentially list conditions b.		
	י ק	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury		
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):		
00,	be executed icien and burial-transit	cal E	Due to (of as a consequence of).		
	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	_	d		
Š	nding use a	N/M	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
Ď	death e atte	Icla	in the past 12 months? 1 Ves 2 VV	□Ectopic pregnancy □ Other (specify)	Month Day Year
5	by th	hys	9 Unknown		
'n.	requires that the death certifica een signed by the attending ph hould be detached for use as th	by F	Part II. Other significant conditions contributing to death but not resulting in the u		bid tobacco use contribute to the cause of death?
cords	s den s	ted	CONGESTIVE HEART FAILURE, ANEMIA,	1	☐ Yes XX No 3☐ Probably 4 ☐ Unknown
ည်		Completed by Physician/Med	FAILURE TO THRIVE, CEREBROVASCULAR A	a	Vas an utopsy 24b. Were autopsy findings available prior to completion of cause of
<u>.</u>		Co			erformed? death? ss 2 □ No 1 □ Yes 2 □ No
	ician certifi ector	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death /Check or	nly one)
5	Phys r this ral dir	. To	1 ☐ Yes X2√2 No 1 ☐ Inpatient 2 ☐ ER/Outpatier 27. Manner of Death 28a. Date of Injury 28b. Time o	Nursing Home 5 F	Residence 6 Other (Specify)
5	Attending Physician: r death. actor: After this certific by the funeral director.	tlor	XXNatural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	f 28c. Injury at 28d. Descri Work? M 1 ☐ Yes 2 ☐ No	
VISION	Attendir death.	Ifice	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str	reet, factory, office 28f. Location	on (Street and Number or Rural Route Number,
5	spital or Attending Physician: ours after death. Nerel Director; After this certific filled in by the funeral director.	Certification:	4 Homicide building, etc. (Specify)	City of	Town, State)
	To the Hospital or Attenc within 24 hours after death To the Funerel Director; completely filled in by the	edical	29a. Certifier (Check only Medical Examiner: On the bast of my knowledge, deat Check only Medical Examiner: On the basis of examination and/or in	h occurred at the time, date and place, and due to	the cause(s) and manner as stated.
	To the Hos within 24 h To the Fur completely	Medi	and manner stated.		
	To To cor	-	29b. Signature and ville of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	10			D0064208	0.11.04.
	8)		30. Name and address of person who completed cause of death (Item 23a) (Type, SAADIA HUSAIN, M.D. 3227 BEL PRE	,	MD 20906
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	LICID DINING	20000
	Registr	ar	AUG 1 5 2007 Lane 1. Presta		

qugust /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Doctor's Community Hospital Lanham If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 8-8-28 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours 17√ M 2 □ F 233-36-4840 79 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a, State r 28a-f show notified at Landover Hills Prince George's MD Director 10e. Street and Number 10f. Zip Code a or 4408 73rd Avenue 20784 "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ᠫ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examine ones. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Glassman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HUFFINAN Jacob Lee Huffman Rosie Bell Parsons ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4408 73rd Avenue, Landover Hills, MD Margaret Huffman/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 IC Cremation 3 ☐ Removal from State 8/10/07 Metropolitan Crematory 4 □ Donation 5 □ Other (Specify) 21. Signatus of Funeral Service Licensee

John Allen Huffman, Sr.

1. Decedent's Name (First, Middle, Last)

Physician

22. Name and Address of Facility

Gasch's Funeral Home, PA Hyattsville, MD 20781 M01491 //her 28a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumonia DAYS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

Month

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

XXYes 2 ☐ No

West Virginia

White

1.05 PM

Year

2007

Prince George's

14. Race - American Indian,

Black, White, etc.

4c. County of Death

10g. Citizen of What Country?

USA

Specify:

16b. Kind of Business/Industry

Huffman Glass

20c. Location - City or Town, State

Alexandria, VA

landovertills MD 20784

Examiner or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-tran Division or Vital Records, P.O. Box 68760, signed by the funeral director, After this ours after death.

neral Director: A
filled in by the fu within 24 hours a
To the Funeral I
completely filled

Physician

/Medical

Examine

Physician/Medical

Completed by

Be

Certification: To

Medical

23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 08-09-2007



Neelam 31. Date filed (Month, Day, Year)

AUG 1 3 2007



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

74th Ave

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2007 John C. Hughes /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner University Specialty Hospital Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs Jast birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. Months Hours 0872171938 Laurel, MD 213-38-0356 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1≹Yes 2 🗆 No Director P.G. College Park MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20740 USA 5119 Keota Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1⊠Yes 2 No 1960 If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 Ho Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Computer Operator Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Louise Morgan Be ould be f George Hughes 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If Item 27 is any Injury control of Health and Important: If Item 27 is any Injury control of the Item 27 is an 5119 Keota Terrace, College Park, MD 20740 Doris L. Hughes/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 8/15/2007 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licenses 3401 Bladensburg Rd., Brentwood, MD 20722 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardio respirenting failure, Saler Malistration **Physician** /Medical Malignant Melanoma e portonsal **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Carcinomatosis, ESRD, failed Cadvonic Kidney signed by the attending physician and ibe detached for use as the burial-transit dans due to Diobeles Melitis DUT Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed CABG is 2001, Generalized Edumes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 21X No , Reclinery ASCING HYPOAF GETANOMA 2**X** No 1 ☐ Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) <u>2</u> 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide after 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Tefferra, MD

DHMH 17 Rev 1/2001

5

filed within 72 hours after

Baltimore, Maryland 21215-0036

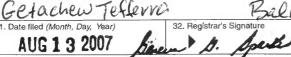
Box

P.O.

or Vital Records,

State Registrar

31. Date filed (Month, Day, Year) AUG 1 3 2007



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

bois Charles St.

		•	1 - For State Registrar	State of M	larylan		artment rtificate			ınd M	Ř	Reg. No.	MA.	/	
rs.	Physici	an	Decedent's Name (First, Middle, Last	st)	** 1						Date of Dea Month	Day	Year	3. Time of	
X.	/Medic	al	Rupert			ton					August	9 200		5:28	A M
1	Examin	er	4a. Facility Name (If not institution, give		r)				Location o	f Death		4c. County		eorge's	
			Prince George's		(1	last birthday)	If Under	ver1	- y If Under 2	24 Hrs.	8. Date of Birth			place (State or	Foreign
At a	Funeral		5. Social Security Number 6. S 579-88-0332	BX ☑M 2□F /. A	80	Yrs.		Days	Hours	Min.	(Month, Day	31 1926	Cou	intry) anama	i oreign
Ļ,	Director		Usual Residence of Decedent	Λ	- 00						nagase	31 1720			
	land ow		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside Cit	y Limits
	Many Harb	ţo	Md Prince	George's	E	Bowie								¹ XYes	2 🗌 No
	r 28s	irec	10e. Street and Number				10f. Zip	Code				10g. Citizen of V	Vhat Cou	untry?	
	filed within 72 hours after death with the Maryland Hygiene. Ather then "neturel", or items 23s or 28s-f show with the Medical Examinat must be multifud at	by Funeral Director	16010 Excalibur	Road			20	716				U.S.A.			
	deal	ner	11, Marital Status	12. Was Deceden		.S. 13.	Was Decede	ent of Hi	spanic Orig	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)		e - Amer k, White	ncan Indian, , etc.	
9	or It	F	1 Never Married 2 Married	1 Tes 2 K			1 Yes 2		Specify:			Specify	. 1	Black	
21215-0036	ural',	d b	3 Nidowed 4 Divorced	Year or Dates	:						1	10) 10:-1-10:			
꺗	72 h	Completed	15. Decedent's Ed (Specify only highest gra	ducation ide completed)		16a. Dece (Give	dent's Usua kind of won DO NOT us	k done d	ation during most	of worki	ng	16b. Kind of Bu	ısıneşs/i	naustry	
12	withir ane. then	E G	Elementary/Secondary (0-12) 8th	Coltege (1-4or	r 5+)	1	xecut					Priv	ate		
2	Hygid ther ant,		17. Father's Name (First, Middle, Last,						18. Mothe	r's Name	(First, Middle,	Maiden Suman	ne)		
an	d be ental	To Be	Leslie Hylton						1	Mary	Henri	quez			
Maryland	Shoul nd Me mark	F	19a. Informant's Name/Relationship (Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	r or Rura	I Route Numbe	er, City or Town,	State, Z	ip Code)207	72
Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinat must be notified at ance.		Leonardo R. Hylto	n/Son		13950) Bish	ops	Becue	est l	Road Upi	per Marl	Lbor	o,Mary1	and
ē,	f Hearlitern		20a. Method of Disposition		20b. I	Place of Dispo					ate	20c. Location -			
OT.	age: ent of nt: If y or		1 Burial 2 Cremation 3 4 Donation 5 Other (Specif		Re	esurre	tion	Ceme	etery	8/1	4/2007	Clinton	n,Ma	ryland	
Baltimore,	artm orter inju		21. Signature J. Funer Service Licer			-	2. Name and			225.0		nkins Fu	mer	al Home	
ä	Depa impo any i			\leq			7474	Land	lover			ver. Mai			
	4 6		23a. Part1. Enter the disease, or com	plications that caus	ed the dea	Do not en								Approximate Interval Bety	9
755	Pnysician		shock, or heart failure. List only Immediate Cause (Final	P D	206		1/1	2	n Am	. 1		0		Onset and D	
	_/Medical		disease or condition resulting in death)	a Due to ()r a	as a consec	quence of):	1		W			(
	Examiner			11-	ine	and.	ess	az	2						
4	1	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or i	saconsec	quence of):		100				illo-			
	be executed sician and burial-transit	Examiner	that initiated events	c											
o`	an ar	EX	resulting in death) Last	Due to (or a	as a consec	quence of):									
1760,	A × 0	cat	(d											
89	death certificat e attending phy id for use as th	Physician/Med	fF FEMALE:								<u> </u>				
Вох	th ce tendi	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1☐Live birth		af death 3[Ectopic pr		,			23d. Da Mo	te of deli inth	,	/ear
E		sici	1 ☐ Yes 2 ☐ No	4∏Pregnant 9☐ Unknown		death 5[Other (sp	ecify)						/	
P.O.	at the ded by the a	Phy	9 Unknown		but act ac	aulting in the c	andosh in a se	-	on in Bort I		23e Did to	obacco use cont	ribute to	the cause of d	eath?
	ires tha signed d be det	þ	Part II. Other significant conditions	contributing to death	i Dui Hot les	saiting in the t	inderlying G	ause givi	en arranti	•		Yes 2□No			Jnknown
oro	w require been si should I	ted												/	
Records,	S S	Completed									24a. Was autop	osv	Were au prior to d death?	topsy findings completion of c	available ause of
=		S									1 Yes		1 🗌 Yes	2 💆 No	
Vital	Physicien: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	Hospital:				Oth	05		h (Check only o				
of	Physic this or	은	1 Yes 2 No	28a Date of Ir		ER/Outpatie			4 🗆 140			dence 6 Oth		cify)	
Ē	After une	0	27. Manyer of Death 1 ☑ Natural 5 ☐ Pending	(Month, L	Day Year)	28b. Time of Injury	M	28c. Injur Wor	yai k? Yes 2□		200. Describe i	now injury occur	100		
Sic	ten feat for: the	icat	Accident investigation	99 Place of	Injuny - At h	nome farm st			163 2	-	28f Location (Street and Numb	er or Ru	ıral Route Num	ber.
Division	of or Attendate death i Director:	Certification:	4 Homicide determined	building,	etc. (Speci	ify)	reer, ractory	y, Onice			City or Tox				
_	To the Hospitel or At within 24 hours after C To the Funerel Direct completely filled in by		29a. Certifier 10 Certifying P	hysician: To the be	st of my kn	owledge, dea	th occurred	at the tir	ne, date ar	nd place.	and due to the	cause(s) and m	anner as	stated.	
	24 h 24 h Fur etely	edical	(Check only 2/1 Medical Exa	miner: On the basis and manner	of examin	ation and/or it	nvestigation	, in my o	pinion, dea	th occur	red at the time,	date and place,	and due	to the cause(s)
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	1			290	c. Licens	e number			29d. Date signe	d (Mont	Dey, Year)	
		1	1/1/1/	1 1				0	30	3/	5	2/9	1/0	7	
	(00)		30. Name and address of person who	completed cause o	of death (Ite	m 23a) (Type	, Print)	-	\ .		1	0/11		/	
2	(20)			VEN15	3001	m 23a) Type +105 hattye	PITAL	&	H.		CHEVEX	LY, M	2	2018	5
7,100	St	ate	31. Date filed (Month, Day, Year)	32. Regi	strar's Sign	lature.						/		*	
	Regist	rar	AUG 1 3 2007	Derew	D. A	pera									

	1- State of Maryland / Department	artment of Health and rtificate of Death	, ,	jiene leg. No.	7 0771.
Physician /Medical	1. Decedent's Name (First, Middle, Last) Leroy Robert Hall		2. Date of Dea Month August	th Day Yea	3. Time of Death 3:15 AM M
Examiner	4a. Facility Name (If not institution, give street and number) Wicomico Nursing Home	4b. City, Town, or Location of Deat Salisbury	h	4c. County of D	eath
Funeral Director	5. Social Security Number 109-10-1100 0. Sex 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		, Year)	Birthplace (State or Foreign Country) ndiana
vith the Maryland or 28a-f show be notified at Director	10a. State 10b. County 10c. City, Town or Low Maryland Wicomico Salisbu	ry			10d. Inside City Limits 1 X Yes 2 ☐ No
s 23a or 2 rust be n	10e. Street and Number 900 Booth Street	10f. Zip Code 21801		0g. Citizen of What USA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No- to Rican, etc.)	Black, W	merican Indian, hite, etc. hite
ed within 72 houygiene. To the Medical Et, the Medical ECOmpleted	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of wor DO NOT use retired) Writer	rking	16b. Kind of Busine:	,
Mental Hy arked other artic event, To Be C	17. Father's Name (<i>First, Middle, Last</i>) Kinsey Elsworth Hall		me (First, Middle, I Mae Crec		
1 and 2 sho Health and I Im 27 Is ma Ther trauma		ng Address (Street and Number or Ric 8 Oxbridge Dr., S	Salisbury		1
nit. Pages bartment of ortant: If it injury or o	1 ☐ Burial 2XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbur	y Crematory 8/1	.0/07	Salisbur	y, MD
permi Depa Impo any is	23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	Hornand Address Unestal 501 Snow Hill Rd. er the mode of dying, such as cardia			ASSOCIACION Approximate Interval Between
Physician /Medical Examiner dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter University: 2 Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):	A ,			Onset and Death
ath certific attending p for use as:		Ectopic pregnancy Other (specify)		23d. Date of o	delivery Day Year
w requires that the diben signed by the should be detached leted by Physic	Part II. Other significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions.	nderlying cause given in Part I.	23e. Did tot		to the cause of death? Probably 4 Donknown
n: The law requi	DEMENTIA.			prior t death No 1 Y	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2: Medical Certification: To Be Compl	25. Was case referred to medical examiner? 1 Yes No	t 3 DOA Other: 4 Nursing H		ence 6 □Other (Spow injury occurred	oecify)
ital or Attending First after death. ral Director; After led in by the funeralled in Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, str building, etc. (Specify)	eet, factory, office	City or Towr	n, State)	Rural Route Number,
the Hosp in 24 hou the Funer ppletely fill	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, deatled the properties of the pasts of examination and/or in and manner stated.	vestigation, in my opinion, death occu	e, and due to the curred at the time, d	ause(s) and manner late and place, and c	as stated. lue to the cause(s)
	29b. Signature and title of certifier MANUALLY T MD 20. Name and address of parson who completed cause of death (Item 22a) (Type	29c. License number D-00605/2		9d. Date signed (Mo	onth, Day, Year)
State Registrar	31. Date filed (Month, Day, Year) 32. Jegistrar's Signature	ernshore Dr Salis	sbury MD	21804	

DHMH 17 Rev 1/2001

HAII

Division or Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar			Cer	tificat	e of L	Death		Re	eg. No.	2007	27745
	Physicia	an	1. Decedent's Name (First, Middle, La Alice Louise	Hruska							2. Date of Deat Month	h Day	Year	3. Time of Death 9:35A M
	/Medic					T		-			August		, 2007	9:33A M
	Examin	er	4a. Facility Name (If not institution, giv						Location of	of Death			County of Death	
			9479 Canary Dri		(In yrs. last birti	hdav)		Alt 1 Year	on If Under:	24 Hrs.	8. Date of Birth		Charles	place (State or Foreign
h	Funeral Director			□M 2XTF		rs.	Months	Days	Hours	Min.	(Month, Day, oruary	Year) 4,19	21 M	place (State or Foreign ntry) aryland
	land ow it		10a. State 10b. County		10c. City, Town	or Loc	cation							10d. Inside City Limits
	Mary -f sh fied a	to	MD Charle	9.5	Be1	A1+	on							1 ☐ Yes 2 XNo
	th the or 28a	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citiz	en of What Cou	ntry?
	th wit 23a c 1st be	a D	9479 Canary Dri	ve				2061	1			1	USA	
	ems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ever in U.S.	13. V	Vas Deced	dent of Hi	spanic Ori	gin? (Spec	cify Yes or No- lican, etc.)	1.	 Race - Ameri Black, White 	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates:	lo		I□Yes		Specify:					White
2-0	72 hc 'natur dical	eted	15. Decedent's E	ducation ade completed)	16a.	(Give I	lent's Usua kind of wo	rk done d	turina mos	t of workin	a	16b. Kin	d of Business/Ir	dustry
2	vithin ne. han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5-		life. E	Cler	se retired)			Gr	ocery S	tore
72	Hygie Hygie ther th	S	17. Father's Name (<i>First, Middle, Last</i>)	1				18 Mothe	r's Name	(First, Middle, N			
ano	d be f) Be	Benjamin Joseph 1								sey Hig		arrane)	
Ž	shoul nd Me mark mark	ဥ	19a. Informant's Name/Relationship (19b.	Mailin	g Address	(Street a					Town, State, Zi	o Code)
S	nd 2: alth ar 27 Is ir trau		Joan Higgs/Daugh	ter	77	41	Ann I	Harb	or Dr	ive,E	ort Tol	acco	o,MD 2	0677
e,	item of Hea		20a. Method of Disposition	3-	20b. Place of cemeter	Dispos	sition (Nar	ne of other plac	e)	Da	ate	20c. Loc	ation - City or T	own, State
Ë	Page nent c int; if iry or		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special		St. Ig					8/17/	′07 🗜 c	ort :	Говассо	,Maryland
Baltimore, Maryland 21215-0036	permit. Departr Importa any Inju		21. Signature of Funeral Service Licer	c- / //	945	22 A	Name ar REHA	d Addres	s of Facilit	y FUNE	ERAL HON	ΊΕ, P	.A.	
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused	the death. Do n	ot ente	er the mod	t . Ma le of dyin	ary's g, such as	Ave.	La P1a respiratory arre	ita,l	MD 206	Approximate
	Physician	10	Illinediate Cause (Fillal	one cause on each lin	e.	(A			Μ	L	tohic		- 0	Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	a.	a consequence o		cer	-	100	1 47	141:0			
K)	Examiner		O THE STATE OF THE	b										
Ĕ.	D #	ner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence o	t):								
	rificate be executed ng physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C		4).								
68760,	be exician a			Due to (or as a	a consequence o	и).								
387	physicate the l	Medical		▲d	<u> </u>									
Box (IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy							23	3d. Date of deliv	erv
ă	death ce attendir d for use	Physician/	in the past 12 months?	1□Live birth 4□Pregnant at	2 🗌 Fetal death		Ectopic pi Other <i>(sp</i>						Month	Day Year
<u>Р</u> О	t the c by the achec	hysi	9 Unknown	9□Unknown										
	ires that the de signed by the a I be detached f	by P	Part II. Other significant conditions	contributing to death bu	it not resulting in	the un	derlying c	ause give	en in Part I.		23e. Did tob	acco us	e contribute to	he cause of death?
ğ	w require been sig should b										1 □ Ye	es 2/2	(No 3□ Pro	bably 4 □Unknown
Vital Records,	2 8 8	Completed									24a. Was ar	v I	prior to co	opsy findings available empletion of cause of
<u> </u>		ပ္ပ									perform	ned? 2XINo	death? 1 🗌 Yes	2□ No
<u>₹</u>	ician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only on			
0	Phys r this	٦.	1 ☐ Yes 2 📉 No 27. Manner of Death	1 ☐ Inpatie	nt 2 ER/Out	<u> </u>			4 □ Nu		e 5X Reside		Other (Special	fy)
Division or	dIng T. Afte fune	Certification:	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) In	njury	м	8c. Injun Worl 1 □ 1	(? Yes 2 ☐		od. Describe no	rvv mjury	occurred	
N S	or Attendater death	ifica	3 Suicide 6 Could not b 4 Homicide determined		ry - At home, far	m, stre	eet, factor	, office		2	8f. Location (St. City or Town		Number or Rui	al Route Number,
	tal or s afte al Dir ed in	Cert		ballang, etc	. (Opecny)				_		City of Town	i, Siate/		
	To the Hospital or Atter within 24 hours after dea To the Funeral Directo completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Ph	nysician: To the best of miner: On the basis of and manner sta	examination and	, death d/or inv	n occurred vestigation	at the tin	ne, date ar pinion, dea	nd place, a ath occurre	nd due to the card at the time, d	ause(s) a ate and	and manner as place, and due	stated. to the cause(s)
	To th within To th compi	Me	29b. Signature and title of certifier	1 -					e number			- 1	signed (Month	Day, Year)
			1/2 /	1 m	フ		J	000	334	426		8/	15/0	7
	50		30. Name and address of person who	completed cause of de	eath (Item 23a) (1	Туре, Г	Print)							
	D525		B. Larry Jenkins,	Jr.M.D. 11	1 LaGra	nge	Ave	. La	Plat	a,MD	20646			
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 6	200/ 32. Registra	ur's Signature	1	book	,						

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division or Vital Records, P.O. Box 68760,

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

after death.

Director: Aid in by the fu completely filled in by

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29c. License number D31660 29d. Date signed (Month, Day, Year)

08/09/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STONER AVENUE HOMAS GALVW MA 291

WASTMINSTER

21157 maryan

State Registrar

Medical

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2007

07-06220

Amended Item 20c per F.D. 08/15/2007 Carroll County, wil

	Amended Item 200 per F.D. 00/13/200/ Carrott County, wit
	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
son	State of Maryland / Department of Health and Mental Hygiene

	State of Maryland / [-For State egistrar	Department of Hea Certificate of Dea		rgiene Reg. No.	2017 2775
Physician/ edical Examiner	Decedent's Name (First, Middle,Last) Nancy Jane Harrison			2. Date of Death Month Day August 12, 2007	3. Time of Death Year 1415 hrs
	la. Facility Name (if not institution, give street and number) Suburban Hospital	· ·	Town, or Location of Death		ounty of Death ntgomery
Funeral Director	5. Social Security Number 6. Sex 7. Age (1 213-34-0124 1 M 2 X F	n yrs. last birthday) If Un 72 Yrs.	der 1 Year If Under 24Hrs ths Days Hours Min.	8. Date of Birth (MM/DD 8/6/1935	(NYYYY) 9. Birthplace (State or Foreign Country)
w any	Usual Residence of Decedent 10a. State 10b. County 10 MD Montgomery	c. City, Town or Location Damascus			10d. Inside City Limits 1 Yes 2 XXNo
th the Maryland 23a or 28a-f show notified at once.	0e. Street and Number	10f. Z	ip Code		n of What Country?
or items 23a or items base of items base of items base of items.	10200 Damascus Manor Rd. 1. Marital Status 1. Never Married 2. Married Armed Forces? 1. Yes 2. X	er in U.S. 13. Was Dece If Yes, spe	872 dent of Hispanic Origin? (Sp cify Cuban, Mexican, Puerto	ecify Yes or No- 14	ed States Race - American Indian, Black, White, etc.
hours after "natural", o Examiner u ted by F	3 X Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed by the secondary (0-12) College (1-4 or 5+)	1 Yes	2 No specify: al Occupation (Give kind of vorking life, DO NOT use reti	ork done 16b. Kin	d of Business/Industry
11215-0036 It be filed within 72 hours afth Anntal Hygiene. arked other than "natural" event, the Medical Examine be Completed by	12th 17. Father's Name (First, Middle, Last)	Deli Cle	18.Mother's Name	(First, Middle, Maiden Su	ppers Food Warehou
and 2 should be filealth and Mental I tem 27 is marked traumatic event,	Harry Brightwell 19a. Informant's Name/Relationship (Type, Print) Billie Jo Wilson (daughte:	W .	Gladys C ss (Street and Number or F nascus Manor	Rural Route Number, City	
Imore Pages 1 nent of H aut: If i or other	20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	20b. Place of Disposition (No crematory or other place Poplar Spring	ame of cemetery, ice)	Date 20c. Lo	cation - City or Town, State lar Springs, MD
Ball Ball Permit Depart Import injury	23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	Burrier	-Oueen Funeral H	tome and Cremat Windigalda, Mock	Ory, P.A. Approximate Interval Between Onset and
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence)	uence of):			Death
ed nsit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that mithated events resulting in death) Last			1 1075. 10	
e execut cian and rial - tra	d. UNPENDED AMENDED				
ox 68760 ath certificate I attending phys or use as the bu	FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1	2 Fetal dea			Date of delivery Ionth Day Year
ires that the desires that the desired by the ab detached for		ut not resulting in the underly	ng cause given in Part I.		e contribute to the cause of death? No 3 Probably 4 Unknown
of Vital Records, g Physician: The law require. ther this certificate has been signered director, page 2 should be To Be Completed				24a. Was an autopsy performed? 1 ✓ Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vital F ysician: this certifu director, 1	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient	2 Z ER/Outpatient 3	26.Place of Death (Check DOA Other Nursin	only one) ng Home 5 Residence	ce 6 Other:
ion of V ttending Phy death. for: After th v the funeral ation: To	27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investigation	28b. Time of Injury 1322 hrs	28c. Injury at Work? 1 Yes 2 ✓ No	28d. Describe how injury Driver auto auto co	ollision
Division o or to the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune edical Certification:	Suicide Could not be determined (Specify) Loca 29a. Certifier			or Town, State) Woodfield Road & Wa	d Number or Rural Route Number, City atkins Drive, Gaithersburg, MD
To the Hospital within 24 hours To the Funeral completely filled	one) 2 Medical Examiner: On the basis of examiner and manner stated.	nation and/or investigation, in	my opinion, death occurred	at the time, date and place	e, and due to the cause(s)
WJL D	29b. Signature and fittle of dertifie		O.C.M.E.		st 13, 2007
QCMS	30. Name and address person who completed cause of dea Mary G. Ripple MD. Deputy Chief Medica	I Examiner 111 Per	n Street, Baltimore, N	1 D 21201	
State	31. Date filed (Month, Day, Year) 32 Registrar's	Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Aungunst 10 pay 2007 ear 3. Time of Death HIRSCH **Physician** 11:04PM /Medical 4b. City, Town, or Location of Death Rockville 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Shady Grove Adventist Hospital Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1**X** M 2□ F 299-34-9017 Director Ohio Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he nortified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Bethesda Montgomery 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20814 4506 Maple Ave. by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married White 1 □ Yes 2 🖾 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Interior Computer Programmer 5 + 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leo Hirsch Sarah Alansky ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4506 Maple Ave., Bethesda, MD 20814 Steven Hirsch / son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Lebanon Cemetery Aug. 12, 2007 Adelphi, MD 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Funeral Service Licensee 254 CArroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** h bours /Medical Due to (or as a consequence of) Examiner TAUNDICE STRUC ME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed TNEMIA attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) certificate has been signed by the irrector, page 2 should be detached 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ funeral 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 ☐ Pending investigation 1 □ Yes 2 □ No Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

444

DHMH 17 Rev 1/2001

10

within 24 hours a

Medical

State

Registrar

29a. Certifier

(Check only one)

eto

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 1 5 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mp

32. Registrar's Signature

ORIGINAL

1-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number
20062999

29d. Date signed (Month, Day, Year)

August 11 200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year \mathbf{P}^{M} Eugene Loyton Jenkins 8. 2007 5:50 August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2∏ F 578-56-5103 Director 65 14, 1942 Washington, DC Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 XYes 2 No Directo Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7506 Georgian Drive 20772 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐xNo Specify: Specify: \$ 3 ☐ Widowed 4 🔀 Divorced Black. al Hygiene.

f other than "natural vent, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Mail Clerk Government 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James L. Jenkins Leitha Gamble မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 is any injury or other trau Ron Eugene Jenkins - Son 7506 Georgian Dr. Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Vet's Cemt. Aug. 17, 2007 4 Donation 5 ☐ Other (Specify) Cheltemham, MD 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Sigri ture of Funeral Service Licenses 4001 Benning Road, NE Washington, DC 20019 23a. Part1 En er the diseas shock, or eart failure. mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 20 52 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has bage 2 s autopsy performe 1∐ Yes 2 or Attending Physician; 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner Death 28d. Describe how injury occurred After 1 1:⊟Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aff

To the Funeral D

completely filled in the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, 32. Registrar's Sign State AUG 1 3 2007

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Ma	ryland / Depa <i>Cel</i>	artment of I			iene	2775
	Dhyoie	ion	1. Decedent's Name (First, Middle, Las	U .				2. Date of Death Month		3. Time of Death
	Physic /Medi		NORMA CHRISTIN		SON			August	Day Year 8. 2007	12:50 P ^M
9	Exami	ner	4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death		4c. County of Dea	
			Holy Cross Hospit 5. Social Security Number 6. Se		(la vara da da bista da la	Silver			Montgo	
	Funeral Director			9	(In yrs. last birthday) 79 Yrs.	Months Days		8. Date of Birth (Month, Day,		thplace (State or Foreign buntry)
	15		Usual Residence of Decedent					Sept. 13	, 1927 Was	hington, DC
	rylan ihow	_	10a. State 10b. County		10c. City, Town or Lo	cation			-	10d. Inside City Limits
	Ba-f-	Director	Maryland Montgom	ery	Silver S _I	oring				1 X Yes 2 No
	tiled within 72 hours after deeth with the Maryland Hygiene. uther than "naturel", or iteme 23a or 28a-f ehow inth, the Medical Evarificat must be notified at	al Dire	10e. Street and Number 1316 Fenwick Lan	e #402		10f. Zip Code 20910		10	Og. Citizen of What Co	•
	er dee	Funeral	11. Marital Status	12. Was Decedent Ex Armed Forces?		Was Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, Whit	rican Indian,
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ② Divorced	1 ☐ Yes 2 No If Yes, Give)	1 ☐ Yes 2 ☐ XNo		, , , , , ,		lack
Ş	ture!	ed I	15. Decedent's Edu	Year or Dates:		dent's Usual Occur			Б	
215	nin 72	Completed	(Specify only highest grad	e completed)	(Give	kind of work done OO NOT use retire	during most of work	ing	6b. Kind of Business/	Industry
212	d with	E	Elementary/Secondary (0-12)	College (1-4or 5+	В (ook Binde	er		Governmen	nt
Maryland 21215-0036	m = 0 5	To Be C	17. Father's Name (First, Middle, Last) Ernest E. Smith				18. Mother's Name Willie	e (First, Middle, M Marie Wo		
ary	permit. Pages 1 and 2 should by Department of Health and Menta Importent: if item 27 is marked eny injury or other treumatic es <u>once</u> .	-	19a. Informant's Name/Relationship (7)	rpe, Print)	19b. Mailin	g Address (Street	and Number or Rur	al Route Number,	City or Town, State, 2	Zip Code)
2	and 2 salth a n 27 i		Charles W. Smith	- Brother	9217	Ispahan	Loop Laur	e1, MD 2	0708	
Baltimore,	of He		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F	lomous lisam State	20b. Place of Dispos	sition (Name of natory or other pla	ce)	Date 2	Oc. Location - City or	Town, State
Ĕ	Pag ment ant: ury o		4 ☐ Donation 5 ☐ Other (Specify)		Ft. Linco	1n Cemet	ery Aug.	15, 2007	Brentwoo	d, MD
3ait	ermit. epart nport ny inj		21. Sign ture of Funeral Service Licens		- CA 22	Name and Addre	ss of Facility Ste	wart Fund	eral Home,	Inc.
	40 = 9		Thurs.	ingiling					ngton, DC	20019
60,	Physician and /Medical Examiner street per private in the printerior in the private in the private in the private in the priva	dicai Examiner	23a. Part Eiter the disease, or complishook, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the sequentially list conditions, and the sequentially list conditions, and the sequential that indicated events resulting in death) Last	Cardiac Due to (or as a of the body to (or a))).	Arrest					Interval Between Onset and Death
68	tifical g phy as th	edi								
Ö	that the death certificate ed by the ettending phys detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Neo 9 Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of deli Month	very Day Year
	w requires that s been signed b should be deta	by P	Part II. Other significant conditions cor Metastatic Breast	tributing to death but	not resulting in the un	derlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Records,	neen s	Completed by	Melalgia					1 Tes	2 No 3 □ Pro	bably 4 Unknown
Sec.	9 4 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8	Jdu.	netargia					24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
	pag at							performe 1 ☐ Yes 2	ed? death? No 1 ☐ Yes	2□ No
<u> </u>	Physician: this certific ral director.	00	25. Was case referred to medical examiner?	ospital:		100	26. Place of Death	Check only one		
o i	Phys	ို	1 ☐ Yes 21€ No ☐ ☐ 27. Manner of Death	1X_Inpatient			4 Li Nursing Hor		ce 6 □Other (Spec	ify)
Division of Vital	Attending r death.	ation	1. Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	28c. Injun Worl	yat k? Yes 2 □No	28d. Describe how	injury occurred	
Divi	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (- At home, farm, stre Specify)	et, factory, office	2	28f. Location (Stre City or Town,	et and Number or Rui State)	ral Route Number,
:	To the Hospitel within 24 hours a To the Funeral completely filled	Medicai	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of r er: On the basis of ex and manner states	annination and/or inve	occurred at the timestigation, in my op	ne, date and place, a pinion, death occurre	and due to the cau and at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
:	To th Within To the	Z e	29b. Signature and title of cartifier	/	1	29c. License	number	290	f. Date signed (Month	, Day, Year)
))	40300	1	D5079	01		ugust 10,	
\cap	(4)		30. Name and address of person who co	n I ted cause of deat	h (Item 23a) (Tyne P	rint)				2007
1-			Damirez Fossett 2	iul Medica	1 Park Dri	ve Silve	r Spring,	MD 2090	2	
	Sta Registra	_	31. Date filed (Month, Day, Year) AUG 1 4 2007	32. Registrar's	Signature					

DHMH 17 Rev 1/2001

Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death AUG. Day 2007 Year MARIE MURIEL **JONES** 11 8:55 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 21579 DONNELL JONES ROAD TALBOT SHERWOOD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Year 1 M 2 X F 83 MARYLAND 218-14-8154 OCT. 16, 1923 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No MD TALBOT SHERWOOD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21579 DONNELL JONES ROAD 21665 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No WHITE Specify. 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 -0-HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CARTER MARSHALL VIOLET E. ABELL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21455 DONNELL JONES ROAD, SHERWOOD, MD 21665 LISA E.JONES-RAYMOND/DAUGHTER 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Important: If It any injury or o 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION 8-13-2007 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) CENTER 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. C.F.S.P Wasph Ostrousk 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final dstructive tulmony Physician disease or condition resulting in death) 15 year ronic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe trial 1□ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Na Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 1 | Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 ☐ Pending investigation illed in by the f 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of persor JEFFREY J. DENTON, M.D., 555 CYNWOOD DRIVE, EASTON, MD 21601 31. Date filed (Month, Day, Year) AUG 13 State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 200^{Year} **Physician** Deborah L. Jones рМ 14, August 3:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 204 Buena Vista Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 7, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1955 1 □ M 2√XF 214-66-8093 51 Yrs. Oct. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1y☐Yes 2☐No Director MD Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 204 Buena Vista Funeral 21613 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Black, White, etc. 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or White 1 ☐ Yes 2 X No Specify. ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Sales Insurance Agent permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 Is marked other? 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Winfred Clevenger Katherine Croft 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 Buena Vista, Cambridge, MD 21613 Ralph H. Jones/Spouse or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State Mid-Shore Crem. Ctr. | 08/15/07 Cambridge, Maryland 22. Name and Address of Facility Framptom, Funeral Home 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) ماده 1 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical the as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) the 9☐Unknown 9 ☐ Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown leted 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perforn certificate 2 XNo ase referred to medical ner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2[3]10 es 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of r of Death 28d. Describe how injury occurred 28c. Injury at Work? atural 5 Pending investigation 1 ☐ Yes 2 ☐ No cident

Division or Vital Records, P.O. Box 68760, Fo the Hospital or Attending Physician:

within 24 hours after death To the Funeral Director:

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2 2 2 3		
ge	25. Was case reference examiner?	
Certification: 10	27. Manner of Dea 1 Matural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	th 5 Pending investig 6 Could n determi
Medical	29a. Certifier (Check only one)	1 Certifyin 2 Medical
ž	29b. Signature and	title of certifier

State Registrar

6 ☐ Could not be

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Eccrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and add

of death (Item 23a) (Type, Print)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

21601

31. Date filed (Month)

and manner stated

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** MARY ENKIHS 2.35 PM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Forestville Nursing Home & Rehab. Forestville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 7, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 4F Year) 1944 Valdosta, Ga. 578-58-4356 Director 63 Usuat Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiane. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show eny fally or other treumatic event, the Madical Examinat must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Maryland | Prince Georges Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 2600 Keating Street #318 20748 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2(XNo Specify. Specify: Black Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 2 Elementary/Secondary (0-12) Federal Government Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Huston Jenkins Pauline Benjamin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esau Williams /Spouse 2600 Keating Street #318 Temple Hills, Md. 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug. 11,2007 Landover, Md. Harmony Memorial 21. Signature of Funeral Service L ²²A Marre and Address of Facility ope . P. A. 5538 Mariboro Pike/Forestville, Md. 20747 23a. Part f. Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Elerosis 1 ultiple **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) inding physician and use as the burial-translt Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending for use as IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 1 ☐ Yes 2 1 No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 24 hours after death.

Funeral Director; A 1 Tes 2 No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 51520 08-01-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. PISHDAD, M.D. WASHINGTON 1328 #310 JOUTHERN Ave. SE 20030 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 4 2007 Registrar

DHMH 17 Rev 1/2001

	1	State	State of Maryland / D	epartment of H Certificate of L			ene 3. No.	27151
Dhusisi		Registrar Decedent's Name (First, Middle, Last)		. 41.		2. Date of Death Month	Day Year	3. Time of Death
Physicia /Medic Examin	al	Joseph K. a. Facility Name (If not institution, give str	Jefferson eet and number)	4b. City, Town, or	Location of Death	August	11, 2007 4c. County of Death	
Funeral		Greater Laurel Heal S. Social Security Number 6. Sex	th & Rehabilitat 7. Age (In yrs. last birt)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Prince Ge	corge's uplace (State or Foreign untry)
Director		578-20-1631 Jsual Residence of Decedent	1 2□F 84 Y	rs.		May 10, 1		yland
within 7.2 hous arise deem will are many and then "naturel", or items 23s or 28s-f show the Wedleal Examiner must be notified at		Oa. State 10b. County Maryland Prince G	eorge's Capit	ol Heights		10	g. Citizen of What Co	10d. Inside City Limits Y Yes 2 No
n or 28 be no	<u>ā</u>	10e. Street and Number 1204 Chapel Oaks Dr	ivo	10f. Zip Code 20743	3	10	United S	
ial Hygiens. Id Hygiens in a ture, or iteme 23a or 28e-f ehow id other then "naturel", or iteme 23a or 28e-f ehow event, the Medical Examiner must be notified at	-		. Was Decedent Ever in U.S. Armed Forces? 1 ☐Xes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	rican Indian,
"nature!" edical Ex	Completed b	15. Decedent's Educi (Specify only highest grade	ation 16a.	Decedent's Usual Dccup (Give kind of work done life. DO NOT use retired	during most of work		6b. Kind of Business/	
h and Mental Hygiene. 7 is marked other then "r Ireumatic event, tra Me.		Elementary/Secondary (0-12) 12 years 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	.S. Postal S	Service 18. Mother's Nam	e (First, Middle, N	Governmen:	t
ked of	To Be	Joseph D. Jefferso	n			Della Bui		
and M is mer		19a. Informant's Name/Relationship (Type Dorothy W. Jeffers		Mailing Address (Street 204 Chapel (
Healt ther		20a. Method of Disposition	20b. Place of	Disposition (Name of ry, crematory or other pla			20c. Location - City or	
Department of Important: If its any injury or o		1 ⊠ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) 21. Sin ture 1 Funeral Service Licen		y Memorial 1	Park Aug.	ewart Fu	neral Home	, Inc.
88 2 8		23a. Part Erver the disease, or complic	ations that caused the death. Do	The second secon			ington, DC	Approximate Interval Between
hysician /Medical		shock or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Inablility to Due to (or as a consequence	o Thrive				Onset and Death Weeks
ate be executed bysicien and ihe burial-transit	i Examiner	Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Due to (or as a consequence					Years
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that the deeth certification by the ettending phy deteched for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	n 3 ⊟Ectopic pregnan 5 □ Other (specify)	су		23d. Date of de Month	olivery Day Year
ries that the signed by a betech		Pan II. Other significant conditions con Hypertension	tributing to death but not resulting	in the underlying cause g	iven in Part I.		bacco use contribute es 2√∑No 3 ☐ F	to the cause of death? Probably 4 Unkno
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	Be	25. Was case referred to medical examiner?	lospital:		ub	ath (Check only or		acity)
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C 5 5 9	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, offic	в	City or Tox		
Hospita 4 hours Funerel (ely fille	edicai C	29a. Certifier (Check only only) Medical Exemi	sicien: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death occurred at the and/or investigation, in my	time, date and ptac y opinion, death occ	uned at the title,	gate and place, and a	20 (5 (110 00000(0)
To the within 2 To the complet	Me	29b. Signature and title of certifier	2 MD		nse number		29d. Date signed (Mo	
5		30. Name and address of person who co	ompleted cause of death (Item 23a) (Type, Print)	3411	17.05	August 1	4, 2007
13	tate	Jagdish C. Shesad	ri, M.D. 14300 G	allant Fox	Lane Bowi	.e, MD 20	/15	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar				C	Certifica	e of	Deat	h		Reg. No	o. ,		y rose solvey	
	State.		1. Decedent's Name (First, M	liddle, La	ist)							2. Date of De	ath	2	V	3, Time of Death	
	Physicia Medic/		MUSETTE JONE	5								AUGUS 1	02	, 20	07 ^{ear}	4:45A №	4
	Examin		4a. Facility Name (If not instit	ution, giv	e street and nur	nber)		4b. City	Town, o	r Locatio	on of Death		40	. County	of Death		
	Andrew Andrews		FUTURE CARE						CLIN					PRI		GEORGES	
	Funeral Director		5. Social Security Number 577 30 4893		Sex 1 □ M 2√2√F	7. Age (In y	76 Yr	Months		If Und Hour	der 24 Hrs. s Min.	8. Date of Bird (Month, Da JULY 2	y, Year	931	Cou	place (State or Foreig ntry) "H CAROLINA	
Т	and w		Usual Residence of Deceder 10a. State 10b. Co			10c.	City, Town o	or Location								10d. Inside City Limits	_
	the Marylar 28a-f show notified at	tor			GEORGES		•	L HEIGH	ITS							XXYes 2□No	
	r 28a	Director	10e. Street and Number						p Code				10g. Ci	itizen of	What Cou	ntry?	_
	th with	a D	7310 WALKER	MILL	ROAD				2074	3			UN	ITED	STA	TES	
	ems sr mu	Funeral	11. Marital Status		12. Was Dece	rces?	U.S.	13. Was Dece	dent of H	lispanic an. Mexi	Origin? (Special)	ecify Yes or No Rican, etc.)	- [ce - Ameri ck, White,	can Indian,	_
2	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. the Med is a same 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at	by	XX Never Married 2		1 ☐ Yes ∑ If Yes, Giv Year or D	⟨2√⊡ No ve ates:		1 ☐ Yes				,			b: BLA		
5	72 hc 'natu dical	etec	15. Dece (Specify only h	edent's E	ducation ade completed)		1 (0	ecedent's Usu Give kind of w	ork done	durina n	nost of work	ing	16b. k	Kind of B	usiness/Ir	ndustry	
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<u> </u>	should and Men s marke umatic	1	19a. Informant's Name/Rela	ionship	(Type. Print)		19b. N	Mailing Addres	s (Street			al Route Numb	er, City	or Town	, State, Zi	p Code)	
Ž	1 and 2 Health a em 27 is		GLADYS WILLI	AMSO	N / SIST	ΓER	731	LO WALK	ER M	ILL	RD.	CAPIT	OL	HEIG	HTS,	MD 20743	
ני ק	of Health of Health fitem 27		20a. Method of Disposition		7Damayal fram	I .	. Place of D cemetery,	isposition (Na crematory or	me of other plac	ce)		Date	20c. L	.ocation	- City or T	own, State	
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Dall	permit. Pages Department of Important; If i any Injury or once.		21. Signature of Funeral Ser	Mas	roll	/					FUNERA ND ROA	L HOME	OF TLA	MARY	ZLAND MD 2	, INC.	
8			23a. Part Enter the diseas shot, or heart failure.	e, or con List only	nplications that o	aused the de	eath. Do not									Approximate Interval Between	
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	/Medical Examiner		resulting in death)		Due to	or as a cons	equence of)	:									
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	that the ed by detact		Part II. Other significant con	ditions	contributing to de	eath but not r	esulting in th	ne underlying	cause giv	en in Pa	art I.	23e. Did t	obacco	use con	tribute to	the cause of death?	
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=	ding Pt		27. Manner of Death XXNatural 5 □ Pe	endina	28a. Date (Mon.	of Injury th, Day Year,	28b. Tin Inju	ne of ury	28c. Injur Wor	y at k?		28d. Describe i	now inju	ary occur	rred		
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	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one) XX Certifier 2 Med	ifying P lical Exa	hysician: To the miner: On the b and man	best of my kasis of exam ner stated.	nowledge, of ination and/	death occurred or investigatio	d at the ti	me, date opinion,	e and place, death occur	and due to the red at the time,	cause(s	s) and m nd place,	anner as , and due	stated. to the cause(s)	
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	5		1/1		~~	V			D2	453	5		AU	GUS1	03,	2007	
	BA		30. Name and address of pe														_
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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		,	For State of Maryland /	Certificate of		Re	g. No.	27761
	Physicia	_	1. Decedent's Name (First, Middle, Last) Alfhild G. King			2. Date of Death Month August	Day Year 8 2007	3. Time of Death 5:50 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center		r Location of Death	riagabe	4c. County of Dea	ith
0.3	Funeral Director		5. Social Security Number 149–40–9109 6. Sex 1□ M 2√√√ 95	irthday) If Under 1 Year Yrs. Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 27,	Year) 9. Bir 1911	thplace (State or Foreign ountry) Norway
	ne Maryland 8a-f show otified at	ector	Connect- Fairfield		airfield			10d. Inside City Limits 1√√Yes 2 No
	n with the	al Dire	10e. Street and Number 260 Birch Road	10f. Zip Code	06824	10	Og. Citizen of What Co U。S	ountry? S.A.
0036	be filed within 72 hours after death with the Maryland ital Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 3 □ No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cubi	dispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi Specify: W	te, etc.
2	n 72 ho "natur edical	Completed	(Specify only highest grade completed)	a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	oation during most of work d)	ing	16b. Kind of Business	/Industry
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land	be d c	To Be (17. Father's Name (First, Middle, Last) Ernst Gobel			e (First, Middle, M ne (unkno	,	
Mary	nd 2 :			b. Mailing Address (Street 60 Birch Roa				Zip Code) 06824
baitimore,	permit. Pages 1 an Department of Hea Important: If item any injury or othe once.		11 IBurial 2 Micremation 3 Hernoval from State 1		ory 8/15	5/2007 in M. Tay	lor Funera	, Maryland al Home
	8.0 E 8 9		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.					Approximate Interval Between
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DIVISION	or Atten after deat Directors in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, building, etc. (Specify)	M 1]Yes 2 □ No	28f. Location (St. City or Town	reet and Number or F n, State)	Rural Route Number,
-	Hospita 4 hours Funeral tely filled	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge and manner stated.					
	To the within 2 To the Semple	Me	29b. Signature and title of certifier Bereym	29c. Licens D 0	se number 0295	7/ 2	9d. Date signed (<i>Mor</i>	nth, Day, Year)
-	DH		30. Name and address of person who completed cause of death (Item 23a	TE Defe	nse Hw	y, Crot	ton, me	21114
	Sta Registi		31. Date filed (Month, Day, Year) AUG 1 4 2007 32. Figistrar's Signature	Smalle				

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Diego Guadalupe Lazaro 10,2007 10:00a August /Medical 4a Fecility Neme (If not institution, give street end number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Medical Center Cheverly Prince George's If Under 24 Hrs. Hours Min. 6. Sex 12 M 2 ☐ F 7. Age (In yrs. lest birthday) If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 3 Months Yrs. Aug. 7,2007 Director Maryland Usuel Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Nems 23s or 28s-1 show traumatic event, the Medical Examinar must be notified at Md Prince George's Hyattsville 1 ☐ Yes 2X No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2003 Oglethorpe Street #204 20782 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 21X No If Yes, Give Year or Detes: 1 Never Married 2 Married 1⊠Yes 2□No Specify: Mexican altimore, Maryland 21215-0020 White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) none none 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Haatth and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event Be Jorge Mendez Maria Del Rosario Lazaro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jorge Mendez/Father 2003 Oglethorpe St.#204 Hyattsville,Md20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 XRemoval from State Puebla, Mexico 8/17/07 Puebla, Mexico 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Faneral Service License PHILIP ACTIVATION FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Examiner The law requires that tha death certificate be axecuted attending physician and for use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as e consequence of): resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? ZX No 1 □ Yes 25 No 1. Yes or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Nnpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manger of Death 28d. Describe how injury occurred 28b. Time of 1 Naturel 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigetion 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital 29a. Certifier (Check only one) edical 1 🗡 Certifying Physiclan: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of ex-minetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) en in anner stated To the Within 2 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) ath (Item 23e) (Type, Print) 30. Name and eddress of person toine , MID

Registrar **DHMH 16 Rev 6/95**

31. Date filed (Month, Day, Year)

AUG 1 3 2007

32. Registrer's Signature

	•	For State Registrar	State of Mary	-	artment of rtificate o		d Mental H	ygiene Rag. No.	de 2	.776
		1. Decedent's Name (First, Middle, Last)					2. Date of E Month	Day Day	Year	3. Time of Death
Physician /Medical		Andrew Francis Law	less, III				8		007	7:05 P M
Examiner		4a. Facility Name (If not institution, give	street and number)		4b. City, Towr	n, or Location of E	eath	4c. County	of Death	
		Atlantic General H			Berli:			Worce		
Funeral		5. Social Security Number 6. Sex	XM 2DE	yrs. last birthday)	If Under 1 Ye Months Day		Min. 8. Date of B (Month, I 9/10/1	Birth Day, Year)	9. Birth	place (State or Foreign htry)
rector		1/1-26-5///	7	1 Yrs.			9/10/1	1935		PA
*		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation					IOd. Inside City Limits
leaded Familiar mant to notified at	5	,								1 ☐ Yes 2X No
150	Director	FL St. Luc	ie	Port St	10f. Zip Cod			10g. Citizen of	What Cou	nta/2
3 č	គ								Wilat Cou	in y:
a a	Funerai	7341 Marsh Terrace	12. Was Decedent Ever	in II S 12 1	349		7 (Specify Vec or N	USA 14 Bar	e - Ameri	can Indian,
2	Š	11. Marital Status 1 ☐ Never Married 2 ★ Married	Armed Forces? 1 ☐ Yes 2 ☐ No	110.3.	If Yes, specify C	uban, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	Bla	ck, White,	
2	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣	No Specify:		Specif	y: Wh	ite
7	Completed by	15, Decedent's Edu		16a. Dece	dent's Usual Oc	cupation		16b. Kind of B	usiness/lr	dustry
1	Set	(Specify only highest grade	e completed)	(Give	kind of work do. DO NOT use rel	cupation ne during most of tired)	working			,
E	Ē	Elementary/Secondary (0-12)	College (1-4or 5+) 4			e Broker		Real I	Estat	e
	O	17. Father's Name (First, Middle, Last)					Name (First, Midd			
- α	₽	Andrew Francis Law	less. Jr.			Dorot	hy Robins	son		
F	F	19a. Informant's Name/Relationship (Ty		19b. Mailir	na Address (Stre		r Rural Route Num		State, Zii	Code)
		Patricia P. Lawles					Port St.			
1		20a. Method of Disposition		Ob. Place of Dispo			Date	20c. Location		
		1 Burial 2 Cremation 3 P	ionioval nom State				20/2007	Courtement	11-	\$7.A
		4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service License					20/2007 Burbage			
e d		21. Signature of Fulleral Service Literist								
		23 Fart1. Enter the fiseas or mpl shock, or heart failure. List only or	met				Berlin,			Approximate
	ca	Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of):	ncen					
weician/Ma	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregna Other (specify				ate of delive	ery Day Year
o A Po	ed by Pr	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the u	nderlying cause	given in Part I.		.*		he cause of death? bably 4 □Unknow
omniet	Completed by							topsy rformed?	Were autoprior to codeath?	opsy findings available ompletion of cause of
	Be	25. Was case referred to medical examiner?				26. Place of	Death Check on	y one)		
	2	1 Yes 2 No	lospital: 1 X npatient	2 ER/Outpatier	nt 3 DOA	Other: 4 Nursi	ng Home 5 ☐ Re	sidence 6 🗆 Ot	her (Speci	fy)
	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	ar) 28b. Time o		njury at Work? 1 □ Yes 2 □ No		e how injury occu	rred	
1	≝	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, st Specify)	reet, factory, offi	ice		(Street and Num Town, State)	ber or Rui	al Route Number,
3 3	Cel		sician: To the best of m	y knuwledgo, deat amination and/or in	h conumed at the	e time, data and a ny opinion, death	dans, and due to the occurred at the time	na nausa(s) and m e, date and place	annar as and due	o the cause(s)
of entering in the control of the co		29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	and manner stated.							
legipa	Medical Cer	(Check only 2 Medical Exami	and manner stated.			ense number		29d. Date signe		•
legipa	edicai	(Check only 2 Medical Exami	and manner stated.				20	T.		
pletely fil	edicai	(Check only 2 ☐ Medical Exami	and manner stated.		0	00641	20 rlin M	8/1	4/	•

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DOROTHY LARMORE AUG. 10 2007 В. 5:45 \mathbf{A}^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner TALBOT HOSPICE HOUSE **EASTON** TALBOT If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 【 F 72 Yrs. 217-30-9836 22, 1934 PENNSYLVANIA Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Funeral Director MD TALBOT r 28a-f EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or iteme 23s or the Madical Examiner must be 902 SOUTH WASHINGTON ST. USA 21601 iges 1 and 2 should be filed within 72 hours after death 1 to Heelth and Mental Hygiene.
If if the Z 1 is marked other than "netural; or Iteme 234 or other traumatic event, the Medical Examinational and or other traumatic event, the Medical Examinational and the second or other traumatic event, the Medical Examinational and the second or other traumatic event, the Medical Examination country. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed by 3 ₩ Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 REGISTERED NURSE EMERGENCY ROOM 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be J. ARLINGTON BENNETT ELIZABETH BAUMGARTNER 19a, Informant's Name/Refationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) A.DIXON FOUNTAIN, III/SON 117 PARRIS LANE, APT. H8, EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Dapartment of H
Important: if ite
any injury or oti 1 Burial 2 □ Cremation 3 □ Removal from State SPRING HILL CEMETERY 8-16-2007 EASTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Fibrillateco Atrial **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Box 68760 Be Completed by Physician/Medical ettending physic I for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. CACION 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown paga 2 should 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Yes 2 No of Vital Hospitel or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No Medical Certification; To hours efter death. Ineral Diractor: After this y filled in by the funeral di 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral I 29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Dhysicia, H0057821 DO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) enterillo, MD 2540 State °13 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** мф August 13, 2007 Rosanita Katherine Lindstrom /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Montgomery General Hospital Olney If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2√□ F Yrs. 563-38-9368 California Director 75 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or items 23a or 28a-f show sminer must be notified at 1 ☐ Yes 2 No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with USA 20906 Funeral 3200 North Leisure World Blvd., #112 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. the M-dical Examiner 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 → Married Specify.White Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker of the and Mental Hygie 27 Is marked other r traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be I and 2 should be fi Health and Mental H ို Mercedes Yzaguirre John D. Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health ar
Important: if item 27 is
any injury or other trau Gary M. Lindstrom/Husband 3200 N. Leisure World Blvd., #112, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition August 17, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 4 □ Donation 5 □ Other (Specify) 2007 Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ESOPHALEA Physician CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Each of the Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed ician and burial-trans Due to (or as a consequence of): physician s the burial P.O. Box 68760, Physician/Medical as ISe 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1☐ Yes 2★No for 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) ed by the a 9 Unknown as been signed by 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page perform 1 Yes certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending F s after death. Certification: Division 1. Natural 5 Pending investigation within 24 hours after deau...

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

To the

Registrar

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature a

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

703EPH KAPLAN

29c. License number

DV

035635

OLNEY.

29d. Date signed (Month, Day, Year)

20815

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend tate of Marylarki Poep attment of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 09:45 P M August 13, 2007 Vivian Ernestine Moran /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Charles La Plata Civista Medical Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 18, 1923 | 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Min. Sept. **Funeral** Virginia 1 □ M 2 X F 83 578-24-4856 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 29a or 28a-f show you jointy or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Director Maryland | Charles Waldorf 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20601 USA 2121 Bonnie Lane Funeral Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes X No Baltimore, Maryland 21215-0036 Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alta E. Smith Samuel C. Amos 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Catherine A. McKinney - Niece 9452 Lafayette Ave., Manassas, VA 20109 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State Ft. Lincoln Cemetery 8-16-2007 Brentwood, MD 4 □ Donation 5 □ Other (Specify) 21. Signat A of Funeral Service Lice 22. Name and Address of Facility 3035 Old Washington Road M00053 Waldorf, MD 20601 Huntt Funeral Home 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DAYS Physician Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes Mellitus, Atrial fibrillation, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No **Osteoporosis** 24a. Was an neral Director; After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No Certification: To 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Linchward 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier August 15th, 2007 D0061616 R. SINDHWAN1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALDURF MD

State Registrar

State 31. Date filed (Month, Day, Year) AUG 1 6 200

PEMBROOKE SQUARE,
Year)
32. Egistrar's Signature
G 1 6 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 7:06 a^M August 9, 2007 MAGLAQUE L. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's 5503 Kennedy Street Riverdale If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🗓 F 47 04-23-1960 Philippines Director 579-21-3470 Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 X Yes 2 No Directo Prince George's Riverdale Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20737 5503 Kenedy Street Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Pilipino ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry 12 Housekeeping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be in nent of Health and Mental is Angel F. Lucas Loretta B. Cruz other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rolando Maglaque - Husband 5503 Kennedy Street, Riverdale, MD 20737 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any injury or o 1 X Burial 2 ☐ Cremation 3 X Removal from State Iba Memorial Cemetery 08/22/2007 Bulacan, Philippines 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. 0 Hyattsville, MD 20781 Gasch's Funeral Home, P.A. MOIH91 ichely harrie Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician HUTELVOSC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the bunial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physiciar by Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Tectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No Į, 4☐Pregnant at time of death 5 Other (specify) detached the 9 Unknown 9 Unknown β Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed be del 1 Yes 2 No 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? Yes 2 2 🗆 No certificate 1∐ Yes Attending Physician: 124 hours after death.

• Funeral Director: After this certific letely filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? 1⊿Yes 2⊟ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

To the To the

State

Registrar

DHMH 17 Rev 1/2001

vador 31. Date filed (Month, Day, Year) AUG 1 3 2007

(Check only one)

29b. Signature and title of certifier

32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

700

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Physician Examiner

signed by

page 2

this certificate

After

neral Director: / / filled in by the f

To the Hospital within 24 hours a To the Funeral C

or Attending Physician:

Completed by

Be

Certification: To

Medical

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

4☐Pregnant at time of death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 🗌 No 3 Probably 4X Unknown 24a. Was an 24b. Were autopsy findings available

					performed? 1∐ Yes 2∑ No	death? 1 ☐ Yes 2 X No
25. Was case referred to	o medical			26. Place of Deat	th (Check only one)	
examiner? 1 Yes 2 No		Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 0	OOA Other: 4 Nursing He	ome 5 Residence 6	Other (Specify)
2 Accident	☐Pending investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred
3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined		ome, farm, street, facto	ory, office	28f. Location (Street and City or Town, State)	l Number or Rural Route Number,
29a. Certifier 1X	Certifying Ph	hysician: To the best of my kno	wledge, death occurre	ad at the time, date and place	and due to the cause(s)	and manner as stated

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title

29c. License number

MD 035078

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

700 Constitution Avenue, NE, Washington, DC 20002 Mohammad Ghandi, M.D.,

State Registrar 31. Date filed (Month, Day, Year) AUG 1 4 2007

9 Unknown

32. Registrar's Signatur

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 16:30 M Margaret Elizako
4a. Facility Name III not institution, give street and number) Merritt Elizabeth -07 /Medical 4b. City, Town, or Location of Death Examiner 4c. County of Death Atlantic 5. Social Security Number Berlin
If Under 1 Year If Under 24 Hrs. Hospital
7. Age (In yrs. last birthday) General Worcester 6. Sex 9. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 132F 90 Yrs. Director 239-03-2331 06-23-1917 Usual Residence of Deceder 10a. State 10b. County 10c. City, Town or Location item 27 is marked other then "naturel", or iteme 23s or 28s-f show other treumatic event, Ire Madical Examinar must be political 10d. Inside City Limits Director Accomack 1 XYes 2 □ No hincoteaque 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Road U.S.A 2333L Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married permit. Pages 1 and 2 should be filed within 72 hours aft Depertment of Heelth and Mental Hygiane. If then 27 is marked other then "naturel, or i eny injury or other treumatic event, the Marter once." Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Volo Specify: ģ Specify: 3 NWidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Saks Tom's Cove Campground 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be J. Beebe Daniel lizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Ann Smith
20a. Method of Disposition Daughter 1090 Gent Wayre lane
20b. Place of Disposition (Name of cometery, crematory or other place)

Date New Church, UA 23415 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 8/15/67 4 ☐ Donation 5 ☐ Other (Specify) John W. Taylor Cemetery Temperanceville, UA 22. Name and Address of Facility Chincottague, UH 73336 21. Signature of Funeral Service Licensee amando C- Betts Salver Funcial Home, Inc. 6327 Church St. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Atheroscleration Onset and Death Immediate Cause (Final Cardiovocalo **Physician** disease or condition resulting in death) Teur. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attanding physicien and for use as the burial-transit Due to (or as a consequence of) Be Completed by Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a P.0. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Danentea 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Ûnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a Was an certificate 1 Yes 2 No Vital After this certifice a funeral director, p 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA o 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred or Attending Division 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.
To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Widolay Bondelia Heglung Ferret Telend, De 19944 1209 Corrected حير 31. Date filed (Month, Day, Year) 32. Registrar's Signature **AUG 13** Registrar 2007

DHMH 17 Rev 1/2001

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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 **Physician** SLATER MORRIS AUG. 10 10:51 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TALBOT THE MEMORIAL HOSPITAL AT EASTON EASTON 6. Sex 1**X** M 2 ☐ F If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year)
FEB. 26, 1939 Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** MARYLAND Director 214-36-5309 68 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10d. Inside City Limits TALBOT TRAPPE MD 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ms 23a or 21673 29023 ISLAND CREEK ROAD USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: þ Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d other than Elementary/Secondary (0-12) College (1-4or 5+) 12 TEACHER DRIVING SCHOOL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29023 ISLAND CREEK ROAD, TRAPPE, MD 21673 20c. Location - City or Town, State TRAPPE, MD 21673 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
200 S. HARRISON ST., EASTON, MD 21601 Approximate Interval Between Onset and Death 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 🌠 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 200

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		1 - State Registrar			Certific	ate of	Death			Reg. No.	7	9777
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/Medi		4a. Facility Name (If not institution,	, give street and number)		4b. C	ity, Town, o	r Location of				County of Deat	
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P.		Usual Residence of Decedent										
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lled \ Hygie her 1	ပိ	17. Father's Name (First, Middle, L	l not)		Dellik	rerre.		de Name	(Final Stinal)			Institution
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d Me nark	은					10:					Moore	
12 sh h and 7 is n traur		19a. Informant's Name/Relationsh			9b. Mailing Addr							
1 and Health		Kevin W. Weddle	e / Son		7 Chapel				rsvill ate		ryland	21793
ges it of h		1 X Burial 2 ☐ Cremation	3 ☐Removal from State	I	of Disposition (I etery, crematory of						cation - City or	
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Inpportant of Health and Mental Hygiene. Inpportant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service L	icensee	-							ral Hom	
<u> </u>		Maymore	x telera	on							ck,Mary	land 21702
		23a. Part1. Enter the disease, or on the shart failure. List of	complications that caused only one cause on each lir	the death. D	o not enter the n	node of dvir	an alled an					Annrovimata
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Ing Physician: The law requires that the death certificate be executed the part of the standard of the standard of the standard director, page 2 should be detached for use as the burial-transit and the standard of the stan	To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as b	a consequence a consequence a consequence a consequence pf pregnancy 2 Fetal death time of death ut not resulting y Year) 28b ury - At home, c. (Specify) of my knowled f examination a	De of): De	c pregnancy (specify) g cause giving DOA Oth 28c. Injur Worl 1 tory, office	26. Place er: 4 Mu y at k? Yes 2 1	of Death rsing Hom	23e. Did 1	tobacco us Yes 25 an psy ormed 2 22 No one) idence 6 how injury Street and wn, State) cause(s) , date and	Month se contribute to No 3 Pro 24b. Were au prior to c death? 1 Yes Other (Spect	Interval Between Onset and Death Oset and Death Oset and Death Oset Oset Oset Oset Oset Oset Oset Oset
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			1 - For State of Maryland / De Registrar	epartment of F Certificate of		nd Mental Hy	/giene	07 27772
	Physici		1. Decedent's Name (First, Middle, Last) Juanita M. Merson			2. Date of D Month Augus	eath Day	3. Time of Death 10:45 P M
	/Medi Examir		4a. Facility Name (If not institution, give street and number) Westminster Nursing & Rehab. Cente	4b. City, Town, c			4c. County Carro	of Death
	Funeral Director		5. Social Security Number 219–10–1356 6. Sex 1 M 2 XF 7. Age (In yrs. last birthe 79 Yr Usual Residence of Decedent	Months Dave		Min. (Month, D	irth ay, Year) 1, 1927	9. Birthplace (State or Foreign Country) Maryland
	Maryland -f show	tor	10a. State 10b. County 10c. City, Town of Maryland Carroll Westmin					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23a or 28s	Funeral Director	10e. Street and Number 2561 Coon Club Road	10f. Zip Code 21157			10g. Citizen of W	•
336	urs after dea al', or Items caeminer m	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	lispanic Origin an, Mexican, P Specify:	? (Specify Yes or N Puerto Rican, etc.)		e - American Indian, k, White, etc. White
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any fujury or other traumatic event, the Macdical Examinar must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ecedent's Usual Occup Give kind of work done fe. DO NOT use retired retary	during most of	f working	16b. Kind of Bu	
Maryland 2	uld be fitted v flental Hygie rked other i lic svent, III	To Be Co	8 17. Father's Name (First, Middle, Last) Edwin Austin Gibson	recary		Name (First, Middle Miller	1	
Mary	d 2 shot th and N 7 is ma traumat			lailing Address (Street				
altimore,	Pages 1 an ient of Heeli nt: If item 2 ry or other		20a. Method of Disposition 1 🕅 Burial 2 Cremation 3 DRemoval from State 20b. Place of Disposition	1 Coon Club isposition (Name of crematory or other place idge Mem. I	ce) Δ11	Westmin Date 10, 2007	20c. Location -	ryland 21157 City or Town, State e, Maryland
Balti	permit. Depertrimporta any inju		21. Signature of Funeral Service License M01072	22. Name and Addre	ss of Facility	Eline Fun	eral Hom	
	Physician /Medical by secured by secure of the parial-transit five parial-transit for the p	al Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	HD ENTIA	g, such as car	diac or respiratory a	arrest,	Approximate Interval Between Onset and Death
O. Box 6	the death certifi y the attending iched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3 □Ectopic pregnancy 5 □ Other (specify) _	,		23d. Date Mon	e of delivery hth Day Year
rds, P.	es ti igne	ρ	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause giv	en in Part I.			ibute to the cause of death? 3 Probably 4 Unknown
I	The ate h page	Completed				24a. Was auto perfo	psy pr prmed/? de	Vere autopsy findings available rior to completion of cause of eath? ☐ Yes 2☐ No
VIE	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	tient 3□ DOA Oth		Death Check only		
	Attending Phyric death.	atlon: T	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time (Month, Day Year) 28b.	e of 28c. Injury		ng Home 5 ☐ Resi 28d. Describe	how injury occurre	
UIVISION	To the Hospital or Attenwithin 24 hours after deating to the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)			City or To	wn, State)	er or Rural Route Number,
	in 24 ho in 24 ho hs Fune pietely fi	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, discovery one) Certifying Physician: To the best of my knowledge, discovery one one of the best of my knowledge, discovery one one of the best of my knowledge, discovery one of the best of my knowledge, discovery one of the best of my knowledge, discovery one of the best of my knowledge, discovery one of the best of my knowledge, discovery one of the best of my knowledge, discovery one of the best of my knowledge, discovery one of the best of my knowledge, discovery one of the best of my knowledge, discovery one of the best of my knowledge, discovery one of the best of my knowledge, discovery one of the best of my knowledge, discovery one of the best of my knowledge, discovery one of the best of the bes	ath occurred at the time investigation, in my of	ne, date and pl pinion, death o	ace, and due to the occurred at the time,	cause(s) and man date and place, a	nner as stated. nd due to the cause(s)
	To the within 2 To the complete	2	29b. Signature and file of certified And M. D.	29c. License	5955	54	29d. Date signed	(Month, Dey, Year)
	3		30. Name and address of person who completed cause of death (Item 23a) (Type Court SHANAR C. MAGANAR	pe, Print) TOUT POUL	EM	O WEST M	INSTER	MD 21157
	Sta Registra		31. Date filed (Month, Day, Year) AUG 0 9 2007 Serve #	South !				· · · · · · · · · · · · · · · · · · ·

			1 - For State Registrar	State of Mary	•	artment of F			giene Reg. No.	27773
	Physici	an	1. Decedent's Name (First, Middle, Last	-	_			2. Date of De Month	ath Day Yeer	3. Time of Death
	/Medic		Karny		3126			Aug	9 2007	
}	Examin	er	4a. Facility Name (If not institution, give	street and number)	-0	4b. City, Town, or	C.,	ath v	4c. County of Death	n Daner 4
			5. Social Security Number 6. Se		yrs. last birthday)	5/10er	If Under 24 Hr	(1		hplace (State or Foreign
	Funeral Director		·	M 2⊠F	86 Yrs.	Months Days	Hours Mir	. (Month, Da	iy, Year) Co	untry)
			Usual Residence of Decedent			<u> </u>		OCCODE	24, 1720 1010	Julia
	how		10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits
	Sa-1-	cto	Maryland Montgom	ery		Silver Spr	ing			1 ☐ Yes 2 Ñ No
	filed within 72 hours after death with the Maryland Hydione. ther than "natural", or Items 23a or 28a-f ehow int. Ite Madical Examinar must be notified a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	untry?
	ath w	rai	11309 College View				20902		U.S.A.	
	er de	Funerai	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (in, Mexican, Pue	Specify Yes or No orto Rican, etc.)	14. Race - Ame Black, White	
36	s aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		Specify:	White
21215-0036	hour	ed t	15. Decedent's Edu		16a Dece	dent's Usual Occup	ation		16b. Kind of Business/	
5	in 72	Completed	(Specify only highest grad	e completed)	(Give	kind of work done of DO NOT use retired	during most of w	orking	100. Killd of Businessy	industry
7	iene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+) 4		Teacher	,		Public :	Schools
g	Hygothe	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle	, Maiden Sumame)	50110013
<u>a</u>	Aentai Aentai rked o	To B	Frederick Brown				S	uma Alley		
Maryland	should and Men 8 marks umatic		19a. Informant's Name/Relationship (T)	pe, Print)	19b. Mailir	ng Address (Street	and Number or F	Rural Route Numb	er, City or Town, State, 2	ip Code)
	and 2 Belth a n 27 ig		Harry N. Maragides	· Spouse	11309	College Vi	ew Drive,	Silver Spi	ing, Maryland	20902
an a	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F		Ob. Place of Dispo cemetery, crer	sition (Name of matory or other place	ea)	Date	20c. Location - City or	Town, State
Ĕ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Important: If them 27 is marked other than "natural; or Itema 23a or 28a-1 show eny injury or other traumatic event, the Madical Examinar must be notified at once.		4 Donation 5 Other (Specify)		Parklawn M	lemorial Par	k 8/1	4/2007	Rockville, M	aryland
	Depart Import eny In		21. Signature of Funeral Service Lights	9e / / /	A H	2. Name and Address ines-Rinald	ss of Facility i Funeral	Home, Inc.		
0	<u>₹</u> 058a		Jamas	-rem					ver Spring, Man	cyland 20904
	Physician /Medical		23a Part1. Enter the disease, or complete shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Braker	1 . (er the mode of dyin	g, such as cardia			Approximate Interval Between Onset and Death
ı	Examiner		1	Due to (or as a cor	416	one Si	rache	R		91
_	le be executed /siclen and e burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor					nol	ME
8760	sicler buris	dical E	L.				K	10. W		
687	ficate p phys			J		11 7			130/	
	death certificate be executed e attending physicien and ed for use as the buriat-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of print 1 Live birth 2 1 4 Pregnant at time	Fetal death 3	Ectopic gragnancy Other (specify)		4	23d. Date of deli Month	very Day Year
o.	et the	hys		9∐ Unknown		*				
Records,	law requires that the di es been signed by the 2 should be detached	leted by I	Parl II. Other significant conditions con	ntributing to death but not		nderlying cause give	en in Part I.		obacco use contribute to Yes 2 □ No 3 □ Pro	b
ပ္မ	law r	ple						24a. Was		topsy findings available completion of cause of
_	The lav	Comple						perfo	rmed? death? 2 XNo 1 ☐ Yes	
Vital	Attending Physiclen: Thr death. •ctor: After this certificete by the funeral director, pag	Be	25. Was case referred to medical examiner?					ath Check only o		
6	Physical this call direction	၉	100 162 5 140		2 ER/Outpatien		4 🗆 Nursing		dence 6 Other (Spec	sify)
Ĕ	tending F death. tor: After the funer	on on	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	-	Work		28d. Describe	now injury occurred	
S	r Attend er death rector: A by the fi	cat	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be	300 Place of Injury		M 10	Yes 2/2 No	396 Lanation (0	18
É	2 2 2 2	Certification:	4 ☐ Homicide determined	28e. Place of Injury - , building, etc. (Sp	pecify) 60>	-994		City or Tov	vn, State) / / 309	al Reute Number,
_	To the Hospital within 24 hours a Yo the Funerel Completely filled		29a. Certifier 1 🗵 Certifying Phys	sician: To the best of my	knowledge, death	occurred at the tim	e, date and place	e, and due to the	ving mp 2 cause(s) and manner as	stated
	P Fur	edicai	(Check only 2 Medical Examinations)	ner: On the basis of exar and manner stated.	mination and/or inv	vestigation, in my or	oinion, death occ	curred at the time,	date and place, and due	to the cause(s)
	To the Hospital within 24 hours a To the Funerel Completely filled	Me	29b. Signature and title of certifier	20		29c. License	number		29d. Date signed (Month), Day, Year)
}	5		MANNINGKI	10)		DR63	579		August 10, 20	07
	Pu I		30. Name a d address of person who co	mpleted cause of death	(Item 23a) (Type,	Print)				
	7		Maria Jeraldine Tay		4	rive, #T3,	McLean, V	A 22102		
Cr.	Sta Registr		AUG 1 5 2007 Year)	32. Registrar's	ignatus					

			1 ≈ For State Registrar	State of Maryl	-	artment of He			ene 007	2777
	Physici	an	1. Decedent's Name (First, Middle, Las	t)				2, Date of Death Month	n Day Year	3. Time of Death
	/Medic		William B.	McKinley				August		1842 ^M
4	Examir	ner	4a. Fecility Name (If not institution, give			4b. City, Town, or Lo	ocation of Death		4c. County of Deat	h
			Ft. Washington			Ft. Wasl			Prince G	
	Funeral Director		5. Social Security Number 6. Se 234-54-8244 Usual Residence of Decedent	7. Age (In)	71 Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 19,	9. Birti Co 1936 Eck	nplace (State or Foreign untry) INAIL, W.Va.
	land ow		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	i within 72 hours after death with the Maryland liene. r then "natural", or items 23a or 28e-1 show the Medical Examine must be multied at	ţ			Washing	gton, D.C.				1)∑Yes 2 □ No
	r 28e	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	h wit	aj D	524 - 44th Stree	t N.E.		20019			United Sta	tes
	dea	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Spe		14. Race - Ame	rican Indian,
9	or ite		1 Never Married 2 Married	1 ∑Yes 2 ☐ No If Yes, Give	1		Specify:	iloan, oto.)	Specify: B1	_
Ö	ural'.	d by	3 Widowed 4 Divorced	Year or Dates:						
5	nat rotter	iete	15. Decedent's Ed (Specify only highest grad		16a. Dece	dent's Usual Occupation kind of work done dur DO NOT use retired)	on ring most of workir	ng 1	6b. Kind of Business/	ndustry
21215-0036	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		pervisor			Federal G	overnment
	Hyg the off	o C	17. Father's Name (First, Middle, Last)	5+		11	8. Mother's Name	(First, Middle, M	laiden Surname)	
Maryland	5 d a 5	00	Joseph B. McKinle	οΛ			Miriah		,	
<u></u>	d 2 should be the and Menta the and Menta 7 is marked traumatic events.	ဥ	19a. Informant's Name/Relationship (T		19b. Mailir	ng Address (Street and			City or Town, State, 2	in Code)
\leq	12 7 Is		Marissa N. White			Burleigh				
<u>5</u>	s 1 and f Healt item 2		20a. Method of Disposition	20	the second second	sition (Name of natory or other place)			0c. Location - City or	
Ę	00-		1 ☑ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)	Tellioval IIOIII State		Veterans	Aug. 20	2007	Cheltenham	Md
Baltimore,	arth arth orts		21. Signature of Funeral Service Lice	, , , ,						, rid.
ä	Pen Imp any any		+AILKOLA	INFOMOIL	785	Alexander 5538 Marib	oro Pike	/forestv	ville, Md.	20747
			23a. Parti. Enter the disease, or comp shock, or heart failure. List only	lications that caused the d	eath. Do not ent	er the mode of dying,	such as cardiac o	r respiratory arre	st,	Approximate Interval Between
	Amount of the price of the pric	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a const.) Due to (or as a const.) Due to (or as a const.)	sequence of).	Coroney	7 Axto	ery D	11º65e	Onset and Death
8760,	ysicia ysicia ne bui	icai		d						
Ö	rtifica ng ph	Med	IF FEMALE:							
P.O. Box	law requires that the death certifica as been signed by the attending ph 2 should be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etel death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
	w requires that been signed t should be det	by	Part II. Other significant conditions co	ntributing to death but not	resulting in the ur	nderlying cause given i	in Part I.		acco use contribute to 2 □ No 3 □ Pro	the cause of death?
Il Records,	The ate ha	Completed						24a. Was an autopsy perform	ed? prior to c	topsy findings available ompletion of cause of 2 No
Vital	ician: T certifical ector, p	Be	25. Was case referred to medical examiner?	In-itali			6. Place of Death			_
o	Physician: r this certific ral director,	ို	1 165 2 X NO		ER/Outpatien	t 3 DOA Other:	4 Nursing Hom		ice 6 Other (Spec	ify)
Ë	After	Certification:	27. Manner of Death 1 ဩNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Work?		8d. Describe hov	v injury occurred	
Sic	Attending r death. ector: After oy the fune	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	On Division A			s 2 No			18
	or Al	ŧ	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	it nome, tarm, stre ecify)	eet, factory, office	2	City or Town,	eet and Number or Ru State)	rai Houte Number,
ш	Hospital 4 hours a Funerel i fely filled		29a. Certifier Certifying Phy	nining. To the base of much			1			
	othe Hospital or Attending Physician: Into 24 hours after death or the Funeral Director: After this certific mplately filled in by the funeral director,	Medical	(Check only one) 2 Medical Exami	sician: To the best of my liner: On the basis of exam and manner stated.	ination and/or inv	estigation, in my opini	date and place, a ion, death occurre	nd due to the cau d at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
		Me	29b. Signature and title of certifier	w		29c. License no	umber	290	d. Date signed (Month	, Day, Year)
	F 3 1 0		Dand Thromb	MA		Doos			111/17	P.
	(3/	-	30. Name and address of person who co		tem 22a\ /Tues		- /		(////	
	Flo		Arbind Narasimha			*	t. Washi	ngton. M	ld. 20744	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature			G , 1.		
	Registra		AUG 1 5 2007 San	www N. Ap	ele					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician august **PHYLLIS GRAGG** McNAMEE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Lanham Prince George's 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Months Days Hours Min Director 579-20-7088 83 July 2, 1924 Ohio Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or ms 23a must b 7021 Hunter Lane Funeral 20782 U.S.A. Items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Examiner 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 🗓 No φ Specify: White 3 Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) ortant; If item 27 is marked other than "natu injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be 1 nent of Health and Mental A. Ronda Gragg ပ္ Susie Snedegar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lee McNamee Hosea - Daughter 1595 Piscataway Road, Crownsville, MD 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Department of Important; If any injury or once, 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 08-14-07 Alexandria, Virginia 21. Sign vary of Funeral Service Lice, 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, 14 chill M01491 Mu Hyattsville, MD 20781 233 Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACUTE Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner SHIML Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last BOWER Examiner Due to (or as a consequence of). law requires that the death certificate be executed burial-trar Molyuus Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death Month Day Year 5 ☐ Other (specify) ed by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 23e. Did tobacco use contribute to the cause of death? 2 been si 1 Tyes 2 No 3 Probably 4 Unknown Completed page 2 s 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has CHRONI autopsy certificate Division or Vital 1□ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 Impatient 2 ER/Outpatient 3 DOA this Hospital or Attending P 24 hours after death. Funeral Director, After t 27. Manner of Death 28a. Date of Injury After t 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

within 24 hours a the 0

State Registrar

THOMAS MINSUEN 31. Date filed (Month, Day, Year) AUG 1 5 2007

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1525 GREENWAY 32. Registrar

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title

29c. License number

D55559

13

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Physician CORRINE MOSS AUGUST 08, 2007 10:40P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BOWIE der 1 Year PRINCE **GEORGES** LARKIN CHASE NURSING FACILITY 8. Date of Birth (Month, Day, Year) Social Security Number Age (In yrs. last birthday, If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗓 F Months Hours Min Director 168-20-1218 84 2-19-1922 Easton Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. int: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Director Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Federal Hill Court 16909 20716 USA by Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: Black 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Assistant Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bartlett Roberts Jeanette Williams ൧ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any Injury or other train once. 16909 Federal Hill Court Bowie Maryland 20716 Medford - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition T Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Quantico Nat'l Cem. 8-17-2007 Triangle Virginia 21. Signature of Funeral Service Licens 22. Name and Address of Facility Pope Funeral Home 5538 Marlboro Pike Forestville Maryland 20747 23a. Part1. Enter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Approximate Interval Betwee Onset and De **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≽</u> page 2 should be 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2 No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: To Other: 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) Injury 1 Natural To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft To the Funeral Director or Aft To the full of the 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1/CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

De

(Check only one

29b. Signature and title of certifie

AUG 1 5 2007

filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) avakuli

4000

32. Registrar's Signature

29c, License number

29d. Date signed (Month, Dav. Year)

Millalle Ad A312 Bouse NJ

		_	For State Registrar			Marylar		artment of I			Reg. No.		27777
Г	Physicia /Medio		1. Decedent's Name Elaine	e (First, Middle, La LeVata 1	,	elson				2. Date of De Month 08		2007 ^{Year}	3. Time of Death 11:06 P M
1	Examin	_	4a. F <i>a</i> cility Name (// Holy C	f not institution, giv ross Hosp		nber)		4b. City, Town, o	r Location of De			County of Death Ontgome	
4.79	Funeral Director		5. Social Security N 135–36–90		Sex 1 □ M 2 🔀 F	7. Age (In yrs.	. <i>last birthda</i> y 62 Yrs.	Months Days		8. Date of Bir (Month, Date of 9/10/194	y, Year)		pplace (State or Foreign Latry) NJ
	w w		Usual Residence of 10a. State	Decedent 10b. County		10c. Ci	ity, Town or L	ocation					10d. Inside City Limits
	Maryla -f sho iled at	tor	MD	Montgor	nery	Tal	koma P	ark					1 Yes 2 No
	h with the 3a or 28a st be noti	Funeral Director	10e. Street and Nur 7620 M	mber aple Ave	., Apt 4	04		10f. Zip Code	20912		10g. Citiz	en of What Cou	untry? USA
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the M-dical Examiner must be notified at ance.	by	11. Marital Status 1 ⊠Never Marr 3 □ Widowed	ied 2 Married	12. Was Dece Armed For 1 Tes If Yes, Giv Year or Da	ces? 2 🔼 No	J.S. 13	Was Decedent of I If Yes, specify Cub		(Specify Yes or No erto Rican, etc.)		4. Race - Amer Black, White B1 Specify:	
2-0	72 ho natur dical I	eted	(Spec	15. Decedent's E	ducation ade completed)		16a. Dec	edent's Usual Occu e kind of work done DO NOT use retire	pation during most of	working . +	16b. Kin	d of Business/I	ndustry
21215-0036	within ene. than the M	Completed	Elementary/Seco	ondary (0-12)	College (1	-4or 5+)	Execu	tive Admi	nistrat	or	P	rivate	
land 2	ild be filed lental Hygi ked other ic event, til	To Be Co	17. Father's Name John M		')					Name <i>(First, Middle</i> Bronner	, Maiden S	Surname)	
, Maryland	and 2 shouralth and M		19a. Informant's Na Annette		(Type. Print) Parker/s	ister	19b. Mai 1316	ling Address (Street Fenwick	and Number of Ln, Sil	Rural Route Numb ver Sprin	er, City or	Town, State, Z D 20910	Apt.903
Baltimore,	Pages 1 and the second of the			position ☐Cremation 3 [5 ☐ Other (Spec		34_4-	cemetery, cr	position (Name of ematory or other place of coln Crem		Date /15/2007		eation - City or I	
Balti	permit. Departn Importa any inju		21. Signatur	uneral Service Lice	psee			22. Name and Addr 3401 Blade					
r			232. Parti. Enter t shock, or hea	the disease, or sor art failure. List only	pplications that co	aused the dea ach line.	ath. Do not e	nter the mode of dy	ing, such as car	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause disease or condition resulting in death)	on .	a	static orasaconse		t Cancer					years
	Examiner	Jer.	Sequentially list co if any, leading to in cause (Disease or	onditions, nmediate	b. Due to (or as a conse	quence of):						
,	ate be executed hysician and he burial-transit	Examiner	Cause (Disease or that initiated events resulting in death)	5	cDue to (or as a conse	quence of):						
3760,	ate be hysicia he bur	ical			▲d								
.O. Box 68	The law requires that the death certificat te has been signed by the attending phy age 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 9 □ Unknown	months?		irth 2 ☐ Fei ant at time of	tal death 3	□Ectopic pregnand	cy		2	3d. Date of deli Month	very Day Year
٥.	w requires that to been signed by should be detail	þ	Part II. Other signi	ificant conditions	contributing to de	eath but not re	sulting in the	underlying cause gi	ven in Part I.				the cause of death? obably 4 [™] Unknown
Vital Records,	The law requate has been page 2 shou	Completed			*****					24a, Was auto perf 1 Yes		24b. Were au prior to death?	topsy findings available completion of cause of 2 ☐ No
ital	(G)	BeC	25. Was case reference	rred to medical						Death (Check only		10163	20,110
7.	Physician: r this certific ral director,	၉	1 ☐ Yes 2 X] No			ER/Outpati	ell OLIDON		g Home 5 ☐ Res			cify)
Division or	ffe	Certification:	27. Manner of Dea 1 Matural 2 Accident 3 Suicide	tn 5 □ Pending investigatio	on	th, Day Year)	28b. Time Injury	M 1E	Yes 2 □ No	28d. Describe			
Divi	tal or Att s after d al Direct ed in by	Certifi	4 ☐ Homicide	determined	20e. Flace	of injury - At I ng, etc. (Spec	cify)	street, factory, office			(Street and wn, State)		ıral Route Number,
	To the Hospital or Attendi within 24 hours after death.) To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one)		miner: On the b			ath occurred at the investigation, in my	opinion, death		, date and	place, and due	e to the cause(s)
	To the I within 2 To the I complet	M	29b. Signature and	d title of certifier.	al fo	4	- h	D22	se number 990			e signed (Monti	
	BI		30. Name and add	lress of person who	completed caus	e of death (Ite	em 23a) (Typest Gle	e, Print) nn Rd., S	ilver S	pring, MD			

Registrar

DHMH 17 Rev 1/2001

			For State Registrar		Ce.	rtificate of			Reg. No.	7 21713	
	Physicia /Medic		Dolly May Moone August 17 2007 7.50							3. Time of Death	
Examiner			4a. Facility Name (If not institution, giv 113 Franklin Str 5. Social Security Number 6. S	4b. City, Town, or Location of Death Denton If Under 1 Year If Under 24 Hrs. 8. Date			4c. County of Death Caroline of Birth th, Day, Year) 9. Birthplace (State or Foreign Country)				
14. T	Funeral Director		220-03-4656 Usual Residence of Decedent	□M 2 Q F	89 Yrs. 10c. City, Town or Le	Yrs. Months Days Hours Min. (Month, February)			ry 17, 1918 Maryland		
	ne Marylar 8a-f show otified at	ector	10a. State 10b. County Maryland Caroline	2	1 Q _Y Y						
	ath with the s 23a or 2	Funeral Director	10e. Street and Number 113 Franklin Street	Lie w B		10f. Zip Code 21629	liana di Origina (Ca	L	Inited State		
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Marrled 2 ☑ Marrled 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	lo	1 □ Yes 2 / □ No		Rican, etc.)	Black, W Specify:	hite, etc. UCUSION	
21215-0036	filed within 72 h Hygiene. Ither than "natu	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 11 HS grad	ducation ade completed) College (1-4or 5 4	(Give	edent's Usual Occu e kind of work done DO NOT use retire remaker	during most of work	sing	16b. Kind of Busines Home	ss/Industry	
Maryland	2 should be filed w n and Mental Hygie is marked other ti raumatic event, th	Be	17. Father's Name (First, Middle, Last) Napoleon 7	auton			e (First, Middle, Ł Ann Ba	Maiden Surname)		
aryl	shoul and Me s mark	ပ	19a. Informant's Name/Relationship	· · · · · · · · · · · · · · · · · · ·		ing Address (Street			er, City or Town, State	e, Zip Code)	
	1 and 2 Health em 27 i		Charles V. Moore 20a. Method of Disposition	Husba				Denton,	Maryland . 20c. Location - City		
Baltimore,	Page nent o int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice	ý)		Cemeter	y 8-21	-07	Denton	, Maryland	
Ba	permit. Departr Importa any inji		1 Jandeple	PMoure						yland 21629	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate	rrest,	Approximate Interval Between Onset and Death						
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence of):						
P.O. Box (Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnand □ Other (specify) _	су		23d. Date of Month	delivery Day Year	
	w requires that s been signed by should be deta	by	Part II. Other significant conditions	contributing to death b	ut not resulting in the I	underlying cause gi	iven in Part I.		tobacco use contributo Yes 2 ☐ No 3 ☐	e to the cause of death? Probably 4 Conknown	
al Records,	The law re ate has bee page 2 sho	Completed						24a. Was auto perto 1∐ Yes	ormed? death	e autopsy findings available to completion of cause of 1? /es 2 \sumbox No	
or Vital	Physician: this certificant	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nt 2∏ER/Outpatie	ent 3 DOA Ot	26. Place of Dea		one) idence 6 □Other (5	Specify)	
ion or	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation: To	27. Manner of Death 12 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry 28b. Time	of 28c. Inju			how injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Division	tal or Atte s after dea al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (City or To		r Rural Route Number,	
	the Hospital hin 24 hours a the Funeral upletely filled	edical	(Check only 2 Medical Exa	hysician: To the best miner: On the basis o and manner st	f examination and/or i	nvestigation, in my	opinion, death occu	rred at the time	, date and place, and	due to the cause(s)	
	Voith To t	×	29b. Signature and title of certifier	completed cause of d		29c. Licer	5 3 8 /s	-	29d. Date signed (M	onth, Day, Year)	
		_	39 Name and address of person who KoRAH M. Pu	completed cause of d	eath (Item 23a) (Type	NARICET	ST DE	nion	MD 2/6	629	
*	St Regist	ate rar	31. Date filed (Month, Day, Year) AUG 2 0 200		ar's Signature	well a					

ORIGINAL .

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DHMH 17 Rev 1/2001

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** :45 AM 2007 hebba August /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore

order 1 Year | If Under 24 Hrs. University of Maryland Medical Center 5. Social Security Number 8: Sex 7. Age (In yrs. last birt. 8. Date of Birth (Month, Day, Year) 5-28-1946 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Davs Hours Min. Months **X**□M 2□F 61 213-67-3478 Director Gambia Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10b. Count 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Silver Springs 1X Yes 2 No Montgomery Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Gambia #406 20910 930 Wayne Ave Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: Black altimore, Maryland 21215-0036 Ş Q 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Rite Aid Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Customer Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fatou Betty Njie Ousman Niie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Naba Jarra Njie - Wife 930 Wayne Ave, #406,Silver Springs,Md 20910 it of Health a injury or other Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 8-18-07 Serra Kunda, Gambia 1 Burial 2 □ Cremation 3 □ Removal from State Department o Important: If any Injury or once. Family Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 411Kennedy St, N.W.
Universal Mortuary Inc, Wash, D.C. 20011 21. Simature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (as a consequence of): Physician /Medical Examiner Due to or as a consequence of) Gar Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Myelodys plashic

Due to (or as a consequence of): with Syndrame the burial-tran Division or Vital Records, P.O. Box 68760, physician Physician/Medical SBS attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ No. 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an performe 1 Yes 2 XNo certificate 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3□ DOA P this Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 1 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. To the h 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

(2)

State Registrar 32. Registrar's Signature

5

C. M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Miliands

Richards

31. Date filed (Month, Day, Year)

AUG 1 3 2007

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Baltimore

MD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day O9 Year **Physician** 9:52 PM 08 T NANCE 2007 AGNES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Travina BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2 F 83 Jan. 22, 1924 578-22-2636 Baltimore, MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No **Funeral Director** Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20716 1920 Mill Branch Road USA Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: White Be Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Paralegal Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Pittore Rosina Gavazza မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Taylor/Daughter 1920 Mill Branch Road, Bowie MD 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot once. August 16, 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Bladenboro, NC 2007 Singletary Cemetery 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 6512 NW Crain Hwy. Bowie MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Compression to the first of the contract of th Physician 12 hours TRAUMATIC BRAIN INJURY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been approximately approximately the continuous productions and the continuous productions and the continuous productions are continuous productions. as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. FRACTURES 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No 2□ No 1 ☐ Yes 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To nours after death.
neral Director: After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Injury
8:05 AM 5 ☐ Pending investigation 1 ☐ Natural 1 ☐ Yes 2 MNo 08/09/07 PLANE CRASH 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3300 Januarence Hayden Rd 51. Mary 3 (conty Hollywood MD 3□ Suicide determined 4 ☐ Homicide 1 Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year) 4 2007

770 30. Name and addres person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

ADRIAN MAUNE

32. Registrar's Signature

SHOCK TRAUNA

29c. License number

18238

CENTER

29d. Date signed (Month, Day, Year)

08/09/07

	3		State of Maryland / Department of Health and N		-2001 - 1101				
	Physicia	an.	1- State Registrar amended 8-14-07 item #7/wice/partificate of Death 1. Decedent's Name (First, Middle, Last)	Reg. No. 2. Date of Death Month Day Year 3. Time of Death					
	/Medic		Anne M. Nock	Augus	+ 7, 2007 2345				
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death				
			SALISBURY REHAB & NURSING CENTER SALISBURY, MI 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.		WICOMICO				
	Funeral Director		220-03-6019 1 M 2 X F 87 Yrs. Months Days Hours Min.	(Month, Day, Ye	9. Birthplace (State or Foreign Country) -2/29/19/20 yland				
		Director	Usual Residence of Decedent	2/ 3/ 1920	27237 Track yranu				
	s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. If health and Mental Hygiene, If marked other than "neturel", or items 23a or 28a-f show other treumetic event, the Medical Examinar must be multiped at		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits				
92			Maryland Worcester Snow Hill		1 🖫 Yes 2 □ No				
	3a or 2	I Dire	10e. Street and Number 10f. Zip Code 21863	10g	. Citizen of What Country? USA				
	death ms 2;	nera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Status 13. Was Decedent Ever in U.S. 14. Was Decedent of Hispanic Origin? (Status 14. Was Decedent Ever in U.S. 15. Was Decedent of Hispanic Origin? (Status 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 15. Was Decedent of Hispanic Origin? (Status 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 17	pecify Yes or No-	14. Race - American Indian,				
	or ite	by Funeral	Armed Forces? If Yes, specify Cuban, Mexican, Puerto 1 Never Married 2 Married 1 Yes, 2 No 1 Yes, 2 No 1 Yes, 2 No 1 Yes, Sive	o nican, etc.)	Black, White, etc. Specify:				
21215-0036	ure!',	To Be Completed by	3 L& Widowed 4 Divorced Year or Dates:		white				
7	"net		15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work life, DO NOT use retired)	king 16	b. Kind of Business/Industry				
12	withi ene. than		Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker	D	omestic				
	Hygie other ent.		Indirection	ne (First, Middle, Mai					
Maryland	2 should be fited within and Mental Hygiene. Is marked other than eumetic event, 112 M.		Mather Mason Ida H	opkins					
ary	2 should l and Meni Is marker eumetic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru	ral Route Number, C	ity or Town, State, Zip Code)				
	1 and 2 Health tem 27		Wilbur Nock/son 29989 Polks Rd., Pri						
Baltimore,	ges 1 of He or oth		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		c. Location - City or Town, State				
Ē	Pages tment of I tent: If it		'4 Donation 5 Other (Specify) Bowen Methodist Church 8/	-	Newark, MD				
Bai	permit. Pages 1 Department of H Importent: If itel any injury or ott		21. Signature of Funeral Service (censes) 21. Signature of Funeral Service (censes) 21. Signature of Funeral Service (censes) 21. Signature of Funeral Service (censes) 21. Signature of Funeral Service (censes) 21. Signature of Funeral Service (censes) 21. Signature of Funeral Service (censes) 21. Signature of Funeral Service (censes) 21. Signature of Funeral Service (censes)	Home Profe , Salisbur	essional Association Ty, MD 21304				
	Physician /Medical Examiner	_	23/. Part . Enter the disease, or complications that caused the shath. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one causes a state line.	or respiratory arrest	Interval Between				
				Den	Onset and Death				
			resulting in death) Due to +r as a consequence of):	ener	1017				
				easy	geans				
	led nsit	nine	if any, leading to immediate Due to or as a consequence of): cause. Enter Underlying Cause (Disease or injury						
	icate be executed physician and s the burial-transit	Examiner	that initiated events c						
8760,	ate be executed obysician and the burial-transit	dical	U d d d d d d d d d d d d d d d d d d d						
9	tificat ig phy as thi								
Вох	death certific attending pl	M/us	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery				
O. B	ed for	sicia	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Month Day Year				
<u>Ч</u>	that the de led by the a detached t	o Be Completed by Physician/Me	9 □ Onknown	OO - Didash	co use contribute to the cause of death?				
ds,	es De		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown				
Ö	w requir been s should			-					
Records,	has ge 2 :			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?				
a	n: The ficate or, pag		25. Was case referred to medical 26 Place of Dea	1 ☐ Yes 2 🖃					
5	Physicien: The la rthis certificate has aral director, page 2		examiner?	th (Check only one)	e 6 ☐Other (Specify)				
O	g Phy er this eral d	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how					
<u>o</u>	Attending or death.	Certification:	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No						
Division of Vital	or Attence after death Director: in by the	tific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	at and Number or Rural Route Number, State)				
O	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer								
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical (29a. Certifier (Check only Check and due to the caus	e(s) and manner as stated, and place, and due to the cause(s)					
	To the within 2 To the complet		one) and manner stated. 29b. Signature and title of certifier 29c. License number	29d	Date signed (Month, Day, Year)				
	N C		02871	-9 P	31/1-				
	Carrie		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1 /	110/				
	O MAN		WILLIAM ROBINS, M.D. 200 CIVIC AVE., SALISBURY, MD.	21804	(80)				
•.	Sta	te	31 Date filed (Month One Year) 32 Digistrar's Signature						
	Registr	ar	31. Date filed (Worth) PRG 1947 \(\text{2017}\) 2007						

sician and burial-trans attending physician for use as the buria ed by the a should be filled in by the funeral director, After this To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After

Physician/Medical

þ

Completed

Be

Certification: To

Division or Vital Records, P.O. Box 68760

23b. Was decedent pregnant

9 Unknown

1 Yes € No

27. Manner of Death

2 Accident

3 ☐ Suicide

4 ☐ Homicide

(Check only

Natural

in the past 12 months?

☐Yes 2√No

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

9☐ Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 452D

Due to (or as a consequence of):

24a. Was an autopsy performe 2/No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

3. Time of Death

0355

9. Birthplace (State or Foreign

Maryland

White

Approximate Interval Between

DAY

Year

10d. Inside City Limits

1 ☐ Yes 2x No

2007

Cecil

U.S.A.

14. Race - American Indian,

Black, White, etc.

Specify:

25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 ☐ DOA Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29b. Signature and title of certifier Comite

D6663730

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

LINION MOSPITAL, ELILTUR MAMITA 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

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DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician THIEP NGUYEN 4:37 AM August 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner of Maryland Medical Center Baltimore University If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex Months **Funeral** Days Hours 1 🔼 M 2 □ F Vietnam 138-74-8554 67 December 8, 1939 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 21s marked other than "natural"; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he actification. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 X No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20901 U.S.A. 400 E. Franklin Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify Completed by Asian 3 ☐ Widowed 4 K Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Janitor Janitorial 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vinh Thi Nghiem Cong Nguyen ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12911 Crossfield Drive, Beltsville, Maryland 20705 Phuong C. Nguyen - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐Removal from State 8/16/2007 Brentwood, Maryland 4 □ Donation 5 □ Other (Specify) Fort Lincoln Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, of complications that caused shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): year /Medical Examiner Sequentially list conditions, if any, leading to immediate source. Enter the daying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran Due to (or as a consequence of) the attending physician Division or Vital Records, P.O. Box 68760 Physician/Medical been signed by the attending phys should be detached for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 4 Unknown 1 🗌 Yes 2 ☐ No 3 ☐ Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate hes 1∐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗹 Inpatient 2 ER/Outpatient 3□ DOA P 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Certification: 27. Manner of Death 28c. Injury at Work? (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 🖵 Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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Registrar

31. Date filed (Month, Day, Year) AUG 1 5 2007

29b. Signature and title of certifier

32. Registrar's Signature

of Medicine

m

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Department

DHMH 17 Rev 1/2001

29c. License number

22 SOUTH GREENE STREET

29d. Date signed (Month, Day, Year)

Bultmere, MD 2(201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 7:16 A M Robert Walter Orr, Sr. 2001 406051 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Doctor's Community Hospital Lanham 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number Age (In yrs. last birthday) Hours 552-34-9976 Jan. 26, 1933 South Dakota 74 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Greenbelt MD Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20770 USA 333 Westway Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2X No Specify: 3 XWidowed 4 ☐ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronic Equipment Electronic repair 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Inez Jacobs Howard Dewitt Orr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3156 Mallory Square Port Republic, MD. 20676 Robert W. Orr, II / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 08/14/2007 Alexandria, VA. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Highway Bowie, MD. 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Colon Metastatic Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 4□Pregnant at time of death 9□Unknown Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

permit. Pages 1 and 2
Department of Health a
Important: If item 27 is any Injury or attack. Physician /Medical **Examiner** The law requires that the death certificate be executed

Physician

/Medical

Examiner

Director

Funeral

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Completed

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show

ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at

d 2 should be filed within th and Mental Hygiene. 7 is marked other than

Saltimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

or Attending Physician:

To the Hospital

attending physician and for use as the burial-trans signed by the a page 2 s funeral director, this

Examiner Physician/Medical þ Completed Be Certification: To nours after death.

neral Director: 4
filled in by the for

IF FEMALE: 23h. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner?

1 ☐ Yes

27. Manner of Death

1. Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

2 No

24a. Was an performe

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28d. Describe how injury occurred

28a. Date of Injury (Month, Day 5 Pending investigation 6 ☐ Could not be

28b. Time of 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

determined

29c. License number

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

QUEENSBURY RD HYATEVILLE MID YOUT

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medical

31. Date filed (Month, Day, Year, AUG 1 4 2007



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 08-08-2007 CHARLES OLAYINKA Α. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Yrs. 212-06-0325 Director 01-10-1968 Wash. D.C. 39 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1th Yes 2 □ No Maryland Montgomery Director Silver Spring 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20901 9307 Flower Avenue Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 3 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) 04 Montgomery Co. School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecelia Lewis Samuel A. Olayinka ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9307 Flower Ave. Silver Spring, Maryland 20901 Cecelia Olayinka/mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 08-14-2007 Suitland, Maryland 4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 20746 Cedar Hill FH 4111 PA Ave. Suitland, Maryland 23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause Do not enter the mode of dying, such as cardiac or respiratory arrest, nterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a contequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a conse Division or Vital Records, P.O. Box 68760. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 2 No To the Hospital or Attending Physician: within 24 hours after death.

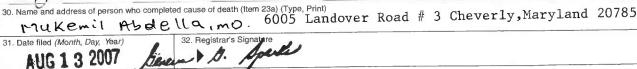
To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 No 2 No 1 ⊠Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Death 28c. Injury at Work? (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 290 License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 08,10,07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7700 Old Branch Avenue Suite 101 Clinton, Maryland 20735 Laxmi Berwa 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

law requires that the death certificate be executed attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760, ed by the a detached f signed to the detail certificate has director, this funeral e Hospital or Attending Pl 24 hours after death. e Funeral Director; After ti After 1 24 hours a completely To the l within 2

1 - For State Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) 12:00 AM **Physician** 2007 August L. Pelham Herbert /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's 8. Date of Birth (Month, Day, Yei Cheverly Prince George's Hospital 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday ^{Year)} 1932 **Funeral** Days Months Hours Virginia 1 € M 2 □ F 577-44-3765 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified a one. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐Yes 2 ☐ No Mitchellville Prince George's Md Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20721 3706 Clairton Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1⊠Yes 2□No Army If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married B1ack 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Government Programme Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Shephard Jones George Pelham ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3706 Clairton Drive Mitchellville, Maryland 20721 Vivian Pelham/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 8/14/2007 | Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signatur - Ineral Service Licens 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 8 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Non-Hodqking Lymphoma Immediate Cause (Final disease or condition resulting in death) End Stage Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4⊡Pregnant at time of death 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? death? 1 ☐ Yes 2 **X**No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 2 ☐ ER/Outpatient 3□ DOA 2 No 1 Tyes Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death (Month, Day Year) Injury 5 ☐ Pending investigation 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 08/09/2007

31. Date filed (Month, Day, Year) State 3 2007 Registrar



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Registrar

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e Hospita 24 hours e Funeral etely fille	29a. Certifier (Check only	e Certifying Physician:		edge, death oo	curred at the	time, date and opinion, death	place, and occurred a	due to the cau the time, dat	use(s) and man e and place, an	nner as stated. nd due to the cause(s)	
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mp		MAN	X /M	tem 23a)		O.C.M.E.			August	7, 2007	
101,	30. Name and a Susan Hi	oddress of person who comp	t Medical Examin	ner 111 F	enn Stree	et, Baltimore	e, MD 21	201			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 10, 2007 Physician Dorice M. Jenkins Pierce 1:36 a^M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Southern Maryland Hospital Clinton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. | 4 Pril 17, 1950 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Mary Land 1□M 2 F 578-68-2802 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Director Maryland | Prince Georges District Heights 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2203 Senator Ave. 20747 United States 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Force: ould be filed within 72 hours after Mental Hygiene. 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Completed by **Black** 3 Widowed 4 Divorced is 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. Item 27 is marked other than "natural", other traumatic event, the Medical Exa 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Employment / D.C. Elementary/Secondary (0-12) College (1-4or 5+) Employment Counselor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willa Mae Creek Dennis Jenkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh
Department of Health and
Important: If item 27 is n
any Injury or other traum 2203 Senator Ave. District Heights, Md. 20747 Raymond R. Pierce /Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Aug.17,2007 Landover, Md. Harmony Memorial 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Pope, P.A. or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one clase on each line. 5538 Marlboro Pike/Forestville, Md. 20747 Immediate Cause (Final ACUTE **Physician** MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examine that initiated events resulting in death) Last burial-tra Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 1 Live birth 2 ☐ Fetal death 3 □ Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a detached t 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown DIABETES Completed LIVER TRANSPLANT 24a. Was an

Hospital or Attending PhysIclan; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, page 2 s funeral director. hours after death uneral Director: / filled in by within 24 hours at To the Funeral D completely filled i

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1∐ Yes 2 1 No 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 1 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

29b. Signature and title of certifier JUDRIC

31. Date filed (Month, Day, Year) AUG 1 5 2007

29c. License number D40324

29d. Date signed (Month, Day, Year) AUGUST 10, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7503 SURLATTS ROAD, CLINTON, MARYLAND 20735 JODRIE, MID

Registrar

Be

Certification: To

Medical

32. Registrar's Signature

and manner stated.

SPO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 13 Rosalie Blanche 2007 6:15 A Poole Aug /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Brighton Gardens of Columbia Columbia Howard If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 X F 579-05-9334 March 5, 1917 Washington, D.C. Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐Yes 2 ☐ No Columbia Maryland Howard Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7110 Minstrel Way #336 21045 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 為☐ No Specify. Specify: Black þ 3√ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be flied within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "r any injury or other traumatic event, the Med once. Elementary/Secondary (0-12) College (1-4or 5+) 12 Statistician <u>Federal Government</u> Unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Crown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8107 F.E. Carter Rd. Laurel, Md. 20707 LeVerne Randol /Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Aug. 17,2007 Adelphi, Md. 4 □ Donation 5 □ Other (Specify) George Washington 21. Signature of Funeral Service Lice 22. Name and Address of Facility Pope Funeral Home 5538 Marlboro Pike Forestville Md 20747 Approximate Interval Between Onset and Death oplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final · U years **Physician** disease or condition resulting in death) /Medical or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of: Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical NIA NIA IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy ate has been signed by the atter page 2 should be detached for u Month Day in the past 12 months? 5 Other (specify) 1 Yes 2 Yo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate 1□ 2 No Yes director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes ပ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Doath 28c. Injury at Work? Certification: 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date the time. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

De

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who comp

snowden River PKWy,

d cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

8600

D56531

29d. Date signed (Month, Day, Year)

Ste 301, Columbia, MD21045

			State of Maryland / D	•						
	o o		Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of	Death	Reg. I	No.	3. Time of Death		
i ng Sig	Physici /Medic		Mildred Vernalie Rowland			August 13	oay 2007 Year	3:22 A M		
)	Examin	er	4a. Facility Name (If not institution, give street and number) 5409 Grove Street	4b. City, Town, o	r Location of Death		4c. County of Dea Montgome:			
-	Funeral	st	5. Social Security Number 6. Sex 7. Age (In yrs. last birt	thday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign		
	Director		414-32-7220	Yrs. Months Days	Hours Min.	July 30,	Jonth, Day, Year) Ly 30, 1921 Tennessee			
	and ww		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits		
	Maryl -f sho fied a	tor	Maryland Montgomery Chevy C	Chase				1 XYes 2 □ No		
	h with the 23a or 28a st be noti	al Director	10e. Street and Number 5409 Grove Street	10f. Zip Code 20815		Uni	Citizen of What Co	L puntry? es		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cub: 1 ☐ Yes 2☑ No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:Whi	te, etc.		
21215-0036	thin 72 hou ie. ian "natura i Medi al E	Completed		Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	eation during most of worki d)	ng 16b	 . Kind of Business	/Industry		
2	led wi dygien her th	S		cretary	40.14-0-2-15			ommission		
Maryland	ild be fi lental F rked ott	To Be	17. Father's Name (First, Middle, Last) L. D. Rowland		Mable Car	(First, Middle, Maid ∵r	en Surname)			
lary	2 shou and M Is mar aumat	-		Mailing Address (Street	and Number or Rura	il Route Number, Cit	y or Town, State, .	Zip Code)		
و ره	1 and 1 Health 1 27 ther tr			Wilson Ln. Disposition (Name of						
Baltimore,	Pages nent of H		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemeter	y, crematory or other place ceek Cemeter	ce)	/2007 Was	Location - City or $hington,$			
Balti	permit. Departr Imports any Inju		21. Signature of Fundral Service Line hsee	22. Name and Addre	ss of Facility Jos	eph Gawle	r's Sons	Inc.		
	27		23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.	ot enter the mode of dyir	ig, such as cardiac c	r respiratory arrest,		Approximate Interval Between Onset and Death		
,	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Acute Leukemia	δ).				3 Months		
	Examiner		Due to (or as a consequence of Myelodysplasia	и):			3 Years			
	uted J ansit	Examiner	Sequentially list conditions, if any leading to immediate cause. Entire Underlying Cause (Disease or injury that initiated events	of):		- 1				
0	ficate be executed physician and is the burial-transit		resulting in death) Last	of):	-					
68760,	icate b physic s the b	edical	d							
P.O. Box (aath certi attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ≅ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	,		23d. Date of del Month	livery Day Year		
	w requires that the d been signed by the should be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause giv	en in Part I.	23e. Did tobacc	o use contribute to	the cause of death?		
ord	equire					1 ☐ Yes	2 ⊠ No 3□ Pr	robably 4 Unknown		
Vital Records,	sician; The law is certificate has be irector, page 2 sh	Completed				24a. Was an autopsy performed 1 Yes 24	prior to death?	utopsy findings available completion of cause of 2 No		
Vita	ician: certifi ector,	Be	25. Was case referred to medical examiner? Hospital: Hospital:	nationt 3D DOA Oth	26. Place of Death	(Check only one)				
	ding Phys n. After this funeral dii	ion: To	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year)	ime of 28c. Injury Wor	4 LI Nursing Hor	ne 5 AResidence 28d. Describe how in		cify)		
Division or	l or Attend after death Director;	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At home, far building, etc. (Specify)			28f. Location (Street City or Town, St	and Number or Ri ate)	ural Route Number,		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune.	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	, death occurred at the tind/or investigation, in my o	me, date and place, a pinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)		
)	To the within 2 To the complet	Me	29b. Signature and the of certifier Many, MD	29c. Licens DO71			Date signed (Mont			
1	(10)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		1				
1			Allen A. Nimetz MD 5530 Wisconsin	Ave. #730 C	hevy Chas	e, MD 208	15			
	Sta Registr	ie ar	31. Date filed (Month, Day, Year) AUG 1 4 2007 Since 32. Registrar's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

John Martin Rodrigu	State of Maryland / Department of 1-For State Registrar Certificate of		ygiene Reg. No.	7 2770
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) John Martin Rodrigues, J	r.		3. Time of Death 2025 hrs
		b. City, Town, or Location of Death Germantown		
Funeral Director	5. Social Security Number 148-42-0385 6. Sex 7. Age (In yrs. last birthday) 41 Yrs	If Under 1 Year If Under 24Hrs Months Days Hours Min.	Foreign	nplace (State or Pennsylvania Intry)
and show any nice.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locati Maryland Montgomery German			10d. Inside City Limits 1 Yes 2 X No
the Maryland a or 28a-f she tified at once	10e. Street and Number 13210 Bayberry Drive	10f. Zip Code 20874	10g. Citizen of What Coun United Sta	
death with or items 23 must be no	11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	S Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto Yes 2 X No specify:	pecify Yes or No- 14. Race - Americ	can Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Meinal Hygene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. To Be Completed by F.	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1 1 Equipment	ts Usual Occupation (Give kind of vost of working life. DO NOT use retinent Operator	Constructi	
21215-C 21215-C ould be filed v Mental Hygi marked oth ic event, the	17. Father's Name (First, Middle, Last) John Màrtin Rodrigues, Sr.	Christin	e (First, Middle, Maiden Surname) ne E. Bitanga	
MD 21 dd 2 should lth and Me an 27 is ma anmatic ev			Rural Route Number, City or Town, State, ermantown, MD 20874	
altimore, I mir. Pages I and partment of Heal portant: If item ury or other tra	1 Burial 2 X Cremation 3 Removal from State crematory or oth	<u> </u>	Date ust 20, 20c. Location - City or ust 20, Frederick,	
Baltir permit. F Departme Importar injury or	4 Donation 5 Other Specify.	lame and Address of Facility sthaven Funeral S	Services, Skkot Cod	ly P.A.
uted animex animos anim	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	ions of chronic alc	lar disease complicated	Death
50, te be executed sysician and burial - transit	IF FEMALE: X AMENDED #1, 23a, per MF, 9871, 1, 23a, 27, per MF, 9871,	/20/08/07 TT	23d. Date of delivery	
Box 6876(he death certificate the attending phys hed for use as the b hysician/Me	23b. Was decedent pregnant in the past 12 months?	tal death 3 Ectopic pregnather (Specify)		Pay Year
cords, P.O law requires that t has been signed by 2 should be detace repleted by F	Part II. Other significant conditions contributing to death but not resulting in the u	Inderlying cause given in Part I.		topsy findings available ompletion of cause of
Vital Rec hysician: The his certificate al director, page	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: Inpatient 2 ER/Outpatient	26.Place of Death (Check 3 DOA Other Nursin	only one) ng Home 5 Residence 6 ✔ Other	: Scene
ivision of V or Attending Phy Directoral After 11 in by the funeral tiffication: T	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of I	1 Yes 2 No	28d. Describe how injury occurred	
	3 Suicide 6 Could not be determined (Specify)	et, factory, office building, etc.	28f. Location (Street and Number or Ru or Town, State)	ral Route Number, City
Divi	29a. Certifier (Check only 1 ☐ Certifying Physician: To the best of my knowledge, death occur one) 2 ✓ Medical Examiner: On the basis of examination and/or investigated and manner stated.		1 1	
Me T T T T T T T T T T T T T T T T T T T	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Mor August 18, 2007	nth, Day, Year)
3		n Street, Baltimore, MD 21	201	
State Registrar		W		

DHMH 17 Rev 1/2001 OCME 2006

		1 - For State Registrar	State	of Marylan	•	artment <i>tificate</i>			•	giene Reg. No.	. U . 7	2.1790	
		1. Decedent's Name (First, Middle	e, Last)						2. Date of De Month	ath Day	Year	3. Time of Death	
Physic /Medi		Doris Louise	Remsberg						August	7 , 20	07	1:00 a. M	
Exami		4a. Facility Name (If not institution College View (umber)		4b. City. T Fred		Location of Deat	h		county of Death		
Funeral		Social Security Number	6. Sex	7. Age (In yrs. i	last birthday)	It Under 1		If Under 24 Hrs		h	9. Birth	place (State or Foreign	
Director		219-36-3526	1□M 2및F	78	78 Yrs. Months Days Hours Min.					, Year) 192	9 Mary	land	
pur &	1	Usual Residence of Decedent 10a. State 10b. County		10c City	v. Town or Lo	cation						10d. Inside City Limits	
faryla	ō	Maryland Freder			ederic							1 ☐ Yes 2 ☑ No	
the N	Directo	10e. Street and Number	LICK	FI	edelic	10f. Zip	Code			10a, Citiza	en of What Cou	intry?	
With 3a or		6204 Jefferson	n Bouleva	rd		1	703			USA		,	
be filed within 72 hours after death with the Maryland lai hygiene. Id itygiene. Id other then "nature!", or iteme 23a or 28a-f ehow event, the Medical Examiner must be notified at	Funerai	11. Marital Status	Armed F		S. 13. V	Vas Decede Yes, speci	ent of His	spanic Origin? (S	Specify Yes or No to Rican, etc.)	- 10	4. Race - Amer Black, White		
urs afte	þ	1 ☐ Never Married 2 ☐ Marri 3 🚰 Widowed 4 ☐ Divorced	ried 1 □ Yes If Yes, G Year or	2 ⊒ No live 24 Dates:	1	I∐Yes 2	X No	Specity:		5	Specify: whi	lte	
2 ho	Completed	15. Deceden	nt's Education	n	16a. Deced				rkina	16b. Kind	d of Business/li	ndustry	
Fin 7	βe	Elementary/Secondary (0-12)	st grade completed Cotlege	(1-4or 5+)	life. D	OO NOT use	e retired)						
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be file d oth	Be	17: Father's Name (First, Middle,					- 1		me (First, Middle,		Sumame)		
should Ind Men	ို	Lawrence A. Doi							E. Buss				
12 sh 12 sh 1 s m	1	19a. Informant's Name/Relations							ural Route Numbe				
T, and 1 and		Lawrence A. Don 20a. Method of Disposition	rsey, Jr.		er 10			nd Stre	et, Wood		Mary I		
Pages nent of the		1 → Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		State Mt.	emetery, cren Hope	Cemet	her place ery	" <mark>8-13</mark> -	-2007			Maryland	
portition of a wall year of 12.12.1000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Important: if item 27 is marked other than "naturel", or iteme 23a or 28a-1 ehow any injury or other traumatic event, the Medical Examinar must be notified at 2006.		21. Sign ore of Funeral Service		1,		Name and			Stauffer Pike, Fr				
_		23a. Part1, Enter the disease, or	r complications that	caused the death							ck, riai	Approximate	
Physician		shock, or heart faiture. List trimediate Cause (Finat disease or condition	only one cause on	each tine.	1	ail	، ۲۰۰۹		,			Interval Between Onset and Death	
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ficate phys s the	edicai		d	·									
certii nding use e	Z.	tF FEMALE: 23b. Was decedent pregnant		utcome of pregna						23	3d. Date of deliv	verv	
that the death certifined by the attending I detached for use es	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		birth 2 ☐ Fetat gnant at time of de nown		Ectopic pre Other (spe					Month	Day Year	
hat the by by detacl		Part II. Other significant condition	ons contributing to	death but not resu	ulting in the un	derlying ca	LISA GIVA	n in Part I	23e Did !	nhacco us	e contribute to	the cause of death?	
w requires that s been signed t should be det	ed by	Breat (ance				g.v.		10	2		bably 4 Unknown	
ne law re has bea	Completed								24a. Was		24b. Were aut	opsy findings available emptetion of cause of	
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hysic his ce	2	1 ☐ Yes 2 No	Hospitat: 1 □	tnpatient 2	ER/Outpatien			4- Nursing I	lome 5 ☐ Resi	dence 6	□Other (Spec	ify)	
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deat deat cctor: y the	fica	3 ☐ Suicide 6 ☐ Coutd	not be 200 Place	e of tnjury - At ho	ome, farm, stre				28f. Location (Street and	Number or Rui	ral Route Number,	
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To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerei Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai	29a. Certifier .≯ Certifyir (Check only one) 2 ☐ Medical	ng Physician: To th Examiner: On the and ma	ne best of my kno- basis of examinat nner stated.	wledge, death tion and/or inv	occurred a restigation,	it lhe time in my op	e, date and place inion, death occ	e, and due to the urred at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)	
To the To the Comp	Ž	29b. Signature and title of certifie	ir O			29c.	License	number		29d. Date	signed (Month	Day, Year)	
		1 Cust	in Le	orse			00	968	9	5	517/	07	
17		30. Name and address of person											
10		Austin Pear	ce 300	0 West 9	th Str	eet,	Fred	erick, N	Maryland	217	02		
St Regist	ate rar	31. Date filed (Month, Day, Year)	6 2007	egistrar's Signa	B A								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) AUGUST 2007 Physician 15 06:05 M THCY ROBINSON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY OLNEY MONTGOMERY GENERAL HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🗖 F 578-24-4474 83 Washington, D.C 23 1923 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County a or 28a-f show t be notified at 10a. State 1 ☐ Yes 2 XNo Rockville Md. Montgomery Director 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 20853 4309 Bel Pre Road United States items 23a must | Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Examiner ☐ Yes 2 1 No f Yes, Give 1 ☐ Never Married 2 ☐ Married White ö 1 ☐ Yes 2 🗷 No Specify: þ 3⊠ Widowed 4 Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien. Important: If item 27 is marked other the any injury or other traumatic event, the once. Homemaker 12 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lena Mezi Arthur Racano 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur W. Robinson / Son 18918 Clover Hill Lane, Olney, Md. 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cem. 8/18/07 Silver Spring, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee Box 5038, Laytonsville, 20882 P. O. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumom Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day for Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 | Yes 2 | No 3 | Probably 4 | Nown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes

Physician /Medical Examiner

death certificate be executed

Box 68760.

P.O.

or Vital Records.

Division

Attending Physician:

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

and attending physician been signed by the should be detached page 2 has certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, Be P Certification:

25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Natural Iniury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

tiscertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

Medical

filed (Month, Day, 1 6

29a. Certifier

29b. Signatų

(Check only one)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 6:00 PM Eber Riley Robert 2007 August 12. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Ft. Washington 1105 Broadview Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year June 8, 1908 5. Social Security Number 7. Age (In yrs. last birthdey) Funeral Months Days Hours tx⊠M 2□F Yrs. 99 Washington, DC 216-10-5690 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examinar must be notified at 1 Yes 2 XX0 Oxon Hill Maryland Prince George's Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20745 IISA 111 Mohican Drive Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Rece - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. illed within 72 hours after 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify. Completed by 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Railway Express Driver Pages 1 and 2 should be filed nent of Health and Mental Hygi ant: If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Eber Harry F. Riley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1105 Broadview Road Ft. Washington, Maryland 20744 David Riley / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 10 = 10 1 = 10 1 Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 08/16/2007 Suitland, Maryland permit. Page Department Important: I any injury o once. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signatur Funeral Service 111 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Farty Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest stack, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC CARCINOMA OF URINARY BLADDER Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed physician and the buriat-transit Due to (or as a consequence of) Physician/Medical 38 IF FEMALE: OSD 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown signed by 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 90 3 ☐ Probably 4 ₺ Unknown 1 ☐ Yes 2 ☐ No Hypertension page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Chronic Atrial Fibrillation autopsy performed? certificate 2 X XVo Hypertensive Cardiac Disease 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specific Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To Residence 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 28d. Describe how injury occurred After 1 🕅 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide IXXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number D24020 08/13/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

#203 Temple Hills, Maryland 20748

4467,01d Pranco Avenue

Kou1

Year)

			State of Maryland / Department of Health 1- State Registrer State of Maryland / Department of Health Certificate of Death			a. No.	2.1123
	• Physicia		1. Decedent's Name (First, Middle, Last) Nellie Ray Shelton	Ņ	Date of Death Month Aug 1	Day 200	3. Time of Death 12:40 A м
	/Medic Examin	al er	4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location 4crescent Cities Center Genesis Riverdale	on of Death		4c. County of D	
N.	Funeral Director		Eldercare		Date of Birth Month, Day, 1		Birthplace (State or Foreign Country) irginia
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	the Mar 28a-f sh	ector	MD Prince Georges Bladensburg 10e. Street and Number 10f. Zip Code		10	g. Citizen of What	1X∑Yes 2 No Country?
	ath with	Funeral Director	5999 Emerson Street 20	710	V N-	USA	A merican Indian,
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It has the marked other than "natural", or Items 23s. or 28a-f show other traumatic event, the Medical Examinar must be multified at other traumatic event, the Medical Examinar must be multified at	b	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Conference of Hispanic Confe	cify:		Black, V	/hite, etc. White
21215-0036	within 72 ho ene. than "natur he wedical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during milife). DO NOT use retired)	nost of working	10	6b. Kind of Busine $Brigg:$	·
	filed wit Hygiene Sther the ent, the	e Com	Meat packer	other's Name (Fir		aiden Sumame)	
Maryland	2 should be f and Mental H is marked of raumatic eve	To B	David McDaniel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num.		Fridle	-	re. Zip Code)
	and 2 st ealth and n 27 is n		Tanya Hernandez/Granddaughter 5714 Avery Park D	rive, De	erwood	, MD 208	355
Baltimore,	permit. Pages 1 Department of He Important: If iter any injury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Conation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery	8/13/07	10.	Oc. Location - City Brentwoo	
Balt	permit. Departr Importe any inje		21. Sonature of Funeral Service Licensee 22. Name and Address of Fac Gasch's Funera		P.A.		Ltimore Avenue 111e, MD 20781
Service Servic	Pnysician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic obstructive pulmonary death of the conditions, but the conditions of the con	as cardiac or res	exacer	bation	Approximate Interval Botween Onset and Death 2 Weeks
68760,	cate be executed physician and the burial-transit	dlcal Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):				
O. Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown			23d. Date o Month	f delivery Day Year
٥	uires that signed b d be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa aterial fibrillation; aortic stenosis	art 1.			te to the cause of death? →Probably 4 □Unknown
Records,	law requir as been si 2 should	Completed	congestive heart failure		24a. Was ar autopsy perform	v prio	e autopsy findings available r to completion of cause of
Vital R	an: The tificate h tor, page	a		Place of Death C	1 ☐ Yes 2	No 1□	Yes 2□ No
of	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	tion: To B	examiner? 1 Yes 25 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 1 Note: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury (Month, Day Year) 28b. Time of Injury Mork? 1 Yes 2	28d		nce 6 Other (w injury occurred	Specify)
Division	al or Attendil s after death. al Director: A ad in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f.	Location (Sti City or Town	reet and Number (, State)	or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	te and place, and , death occurred a	due to the ca at the time, da	use(s) and mannate and place, and	er as stated. I due to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of tention D006420			9d. Date signed (*) August 1	
) (23		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saadia A. Husain 4409 East West Highway, Riverd	dale. MD			
1	St	ate	31. Date filed (Month, Day Year) AUG 1 3 2007 AUG 1 3 2007 AUG 1 3 2007 AUG 1 3 2007				

State of Maryland / Department of Health and Mental Hygiene

		1	= State Registrar Certificate of Death		g. No	2779
	Physicia		1. Decedent's Name (First, Middle, Last) Encor Onajite Sowho	2. Date of Death Month August	1 ^{Day} , 200 ⁷ 7 ^{ar}	3. Time of Death 7:06A M
ķ	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	1
			5636 Whitfield Chapel Road #202 Lanham 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	George's
	Funeral Director		999–99–9999 1 M 2X F 35 Yrs. Months Days Hours Min.	Oct 3,		geria
	yiand at at	1	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	8a-f sh	ctor	Maryland Prince George's Lanham		g. Citizen of What Co	1 ☑ Yes 2 ☐ No
3	23a or 2	Funeral Director	10e. Street and Number 5636 Whitfield Chapel Road #202 10f. Zip Code 20706		Nigeri	La
036	permit. Pages 1 and 2 should be filed within 72 hours after death with fine maryland Department of Health and Mential Hygiene. Department of Health and Mential Hygiene. Important: I fire XT is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: E	
5-0	"natur	leted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	ing 1	6b. Kind of Business/	Industry
121	nied within Hygiene. other than ent, the Me	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 5+ Attorney		Governme	ent
Maryland 21215-0036	al Hyg	BeC	17. Father's Name (First, Middle, Last) 18. Mother's Name Gra	(First, Middle, M	_	
ryla	should be and Mental marked oumatic eve	၉	Joseph Sowho 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rura			Zip Code)
Ma	ind 2 sho alth and 27 Is ma or trauma		Ovwe Sowho (Sister) 5636 Whitfield Chapel	Road #20	2, Lanham	MD 20706
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If Item 27 any Injury or other tr once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State		20c. Location - City or	
II.	artmen vrtant: Injury		4 Donation 6 Other (Specify) 21. Signature of uneral Bervice Lice/See 22. Name and Address of Facility Ren	/2007 don/Hale	Silver Sp	ring, MA Home
Ba	Depar Impor any Ir		Junior Jones 9013 Annapolis Road	l, Lanhan	n MD 20706	
			23a. P. n. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of mock, or heart failure. List only one cause on each line.	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical	4	disease or condition resulting in death) Terminal end stage renal disease process and the stage renal disease process are sulting in death) Due to (or as a consequence of):			
	Examiner		Hypertensive cardiovascular disease	9		
45.	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
Ć	execul in and ial-trar	Exan	that initiated events ' c Due to (or as a consequence of):			
68760,	tificate be executed ig physician and as the burial-transit	dedical	d			
Box 6	death certificate be executed e attending physician and d for use as the burial-transit	an/Med	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of del	ivery Day Year
.O. E	he dea the att	Physician/	in the past 12 months? 1		Workin	
٩,	w requires that the death cer been signed by the attendin should be detached for use		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
ords	equire een sig ould b	ted b	Systemic lupus	1 □ Ye		robably 4 □Unknown
0	The law ate has be	Completed by	Hypertension	24a. Was ar autops perforn	y prior to ned? death?	utopsy findings available completion of cause of
		Be Co	25. Was case referred to medical 26. Place of Deat		2 🕱 No	2 □ No
or Vital	Physician: this certific ral director,	To B			ence 6 Other (Spe	ecify)
ono	ding P	tion:	27. Manner of Death ★ Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Back Injury And Injury M 28b. Time of Injury Work? 1 Yes 2 No	28a. Describe no	w injury occurred	
Division	or Attending ifter death. Director: Afte in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str City or Town	reet and Number or R n, State)	ural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ical Ce	29a. Certifier (Check only (C	and due to the carred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the I within 24 To the I complet	Medical	one) and marner stated. 29b. Signature and title operation 29c. License number	25	9d. Date signed (Mon	th, Day, Year)
^	- s - ō	1	D31528		August 1	3, 2007
()	(()	1				·
1	-(4)	-	30. Name and address of person who come electrons of death (It in 23a) (Type, Print) Margaret E. Akpan, M.D. 6128 Landover Road, Cheve	erly MD '	20785	

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** arrelle 01-2007 6:40AM Iarmie /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** D. G *futurec* ave ineview lintor If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 6. Sex **Funeral** Days Months Hours Min 1□M 2QF 577-82-9835 Yrs. Director 04/30/1973 Washington, D.C. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State r 28a-f ahow notified at 1 √Yes 2 No MDPG Temple Hill Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number rai', or itame 23a or Examiner must be 4213 - 28th Avenue #104 20748 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after I □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed it then "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene. item 27 is marked other than other traumatic event, the M Draft Specialist Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gordon Monrison Barrie Stewart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barrie J. Tatum - Mother 4213 - 28th Avenue #104; Temple Hill, Maryland 20748 Importent: If iten any injury or othe once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 08/09/2007 Suitland, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Buneral Service License 22. Name and Address of Facility Freeman Funeral Services
4504 Beech Road; Temple Hill, Maryland 20748 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) deficience Immune Required **Physician** /Medical Examiner Sequentially list conditions, Due to for as a consequence of Examiner dary leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and Due to (or as a consequence of): attending physicien a for use as the burial-P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live hirth Day Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 No 1 Yes 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No Certification: To 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide after within 24 hours a To the Funeral L t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. å 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 328 Southern Bahram 31. Date filed (Month, Day, Year) 32. Registrar's Signa State AUG 1 4 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Ruth Strand Aug.10,2007 11:25₽ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner National Lutheran Home Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan . 5 , 1913 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1□M 2\ F 473-09-1913 94 Yrs. Minnésota Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, II a Micolcal Examinar must be notified at Rockville Yes 2 □ No Md. Montgomery Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 USA 9701 Veirs Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 le marked other then "n Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 2 Yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tamte Anna Axel Oas ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6758 Surrey Wood Lane, Bethesda, Md. 20817 Pages 1 and 2 sment of Health an lant: If Item 27 legury or other trau Russ Strand - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition **X**☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Cemetery 8/15/2007 Frederick, Md. permit. Page Department of Important: If any njury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hysong Co., Inc. Wash. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 2222-Wisconsin Ave., NW Wash .. DC 20007 23a. Part1. Enter the disease, or comshock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician udden cardiac /Medical to (or as a consequence of): **Examiner** Due to (or is a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? Alzheimers 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: neral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗖 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 🖺 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours af

To the Funeral D

completely filled in 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier D0030612 August 11,200 lern 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9701- Veirs Dr., Rockville, Md. 20850 Dr. Samuel Maller 31. Date filed (Month, Day, Year) AUG 1 4 2007 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) DAMPLE **Physician** LEE MELVIN الح 24 07 /Medical 4c. County of Death 4a. Fasility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Medical Center delisbury Wiczmics giona If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Sex **Funeral** Days Months 1**⊠**M 2□F 264 - 12 - 199 3 Usual Residence of Decedent Director 16-1916 VIRCINIA 10a. State 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Salisbuey Director Wicomico ARY AND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1005 21801 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: W W ∏ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: BIACK à 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired), 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) KESTAURANI - EmployEd 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Se. GER RUCKE DAMPLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON MARYLAND 21801 QUEEN SALISBURY MEVIN 1010 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3.☐ Removal from State ALRES 8-19-07 SALISBURY, Md 21801 4 ☐ Donation 5 ☐ Other (Specify) OREEN 22. Name and Address of Facility 21. Signature of Funeral Service Licenses TUNERAI SIELVARI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ousleni /Medical Examiner Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that litinated events at the cause of the Examiner The law requires that the death certificate be executed the burial-transi and resulting in death) Last Due to (of as a consequence of) signed by the attending physician d be detached for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Division or Vital Records, P.O. 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 1 XNatural 2 Accident 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) o completed cause of death (Item 23a) (Type, Print) WILSUN 30. Name and address of person w Elm Incess 31. Date filed (Month, Day, Year) egistrar's Signature Registrar AUG 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 30nnie 100 M 6. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner =aston Talbot Memoria 9. Birthplace (State or Foreign ear If Under 24 Hrs. 8. Date of Birth (Month, Day, SEPT. 7 5. Social Security Number 6. Sex . Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1941 1 □ M 2 X F Country) MARYLAND Director 216-40-4522 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10a, State 10d. Inside City Limits show "natural", or items 23a or 28a-f shov edical Examiner must be notified at XXYes 2 ☐ No Director MD EASTON TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 706 S. WASHINGTON ST 21601 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year, or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11 Marital Status or other traumatic event, the Medical Examiner Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify. Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 0 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f LAWRENCE GAY MARY BOWERS ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra... ROBERT C. SPRINGER/HUSBAND 706 S. WASHINGTON ST., EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 8/10/2007 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST., EASTON, MD 21601 21. Signature of Funeral Service Licenses Ostruski Joseph C.ESP. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of): ide colitis Examiner (ostridium Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as the use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy certificate 1□ Yes Division or Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 € No ပ 1 ☑npatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death completely filled in by the 3 ☐ Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Description of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eastern

		1 - State Registrar			Ce	rtificate o	f Death	h		Reg. No.		
		1. Decedent's Name (First, Midd	dle, Last)						2. Date of I		Vone	3. Time of Death
Physi	cian	Margaret D. Sco	pin						August	15, 20	Year 007	5:40 a M
Exam		4a. Facility Name (If not institution	on, give street and n	umber)		4b. City, Town	, or Location	of Death	3		County of Dear	
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		5. Social Security Number	6. Sex	7. Age (In y	rs. last birthday)			er 24 Hrs.	8. Date of 8			thplace (State or Foreign
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2 st 2 st 2 st 1 and 1		19a. Informant's Name/Relation				ng Address (Stre					Town, State, 2	Zip Code)
and and ealth		Raymond James Sco	pin, Jr./so			Brink Road				-		
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Baltimore, Maryland 21213-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural; or items 23s or 28s-1 show ery injury or other traumatic event, the Medical Experiment cuts the traillied at	ė l	21. Signature of Funeral Service	Licensee	1	1	Name and Add					STRIP	Tatylero
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Donald L. Sisco, Year August 2007 10:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis HealthCare -The Pines Talbot Easton If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye Nov . 7 .] Birthplace (State or Foreign Country) **Funeral** Days 1 ☐**X**M 2 ☐ F Hours Months 1972 Maryland Director 214-13-1232 34 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23s or 28e-f show other traumatic event, the Medical Examinar must be notified at Easton Talbot MD 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. 906 21601 United States 7080 Lauren Lane Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene Important: if them 27 is marked other then "natural", or item only injury or other traumatic event, the Medical Examples ance. Black, White, etc. 1 Never Married 2 Marned Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Convenience Store Cashier 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Deborah L. Dobson Donald L. Sisco, 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 26699 Tunis Mills Road, Easton, MD 21601 Deborah L. Sisco/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 08/23/07 Richards Mem. Park Easton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ramptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 3 otemin weeks /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a com uence of) Examiner or Attending Physicien: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit immuno de Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetat dea 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 2 Fetat death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) the detached 9□ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 4 Unknown icate has been sig 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 2 No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 2 4 Vursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending death. investigation 1 □Yes 2 □No 2 Accident within 24 hours after deatl To the Funeref Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide filled the Hospitai Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) ROWLEY 610 ANG 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

2 AS

DHMH 17 Rev 1/2001

Sisco

Donald

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 1 1 1 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8 ^{Day} 21 **Physician** 2°007 JAMES LESTER SATCHELL 5:41 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Caroline Home for Hospice Denton Caroline 5. Social Security Number If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday Months Hours Days 1 X M 2 □ F 214-28-8340 80 June 26, 1927 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Caroline Federalsburg 1 ☐ Yes 2√2No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 505 01d Denton Road 21632 United States Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 ☑ No þ Specify: 3€ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Southern States Elementary/Secondary (0-12) College (1-4or 5+) Loading Dock Supervisor Feed Mill 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Curtis Crawford Satchell, Sr. Elizabeth Matilda Miller ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29361 Will Street, Easton, MD 21601 Tina Smith/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🙀 Burial 2 □ Cremation 3 □ Removal from State Eastern Shore VA Cem. 08/24/07 Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Primar 2 monts disease or condition resulting in death) Due to (or as a conse no nce of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown þ Be Completed

Physician /Medical Examiner

and

certificate has

After t

that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

and Mental Hygiene. Is marked other than

permit. Pages 1 and 2 should be filec Department of Health and Mental Hyg Important: If item 27 Is marked other any Injury or other traumatic event, i

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

as the burial-transi attending physician nse for signed by the a d be detached for Certification: To To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After

3 HOIIKIIOWII											
Part II. Other significant conditions	contributing to death but not res	sulting in the underlying	cause given in Part I.		se contribute to the cause of death? ☑ No 3 ☐ Probably 4 ☐ Unknow						
				24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No						
25. Was case referred to medical	26. Place of Death (Check only one)										
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatient 3 ☐ I	Home 5 ☐ Residence 6	Sther (Specify) HOSPICE							
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigati	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury							
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine			ory, office	28f. Location (Street and City or Town, State,	d Number or Rural Route Number,)						
	Physician: To the best of my knaminer: On the basis of examin										

29c. License number

Ednum

53253

29d. Date signed (Month. Dav. Year)

21655

State Registrar

DHMH 17 Rev 1/2001

Medical

(Check only one)

inothy

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) AUG 2 2 2007

MD 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Snieze

ORIGINAL

			For State Registrar	State of Ma	aryland / De	epa	artment of H	lealth a		ntal Hygi		gible.	27805		
	/		Decedent's Name (First, Middle, Li	ast)						Date of Deat	1		3. Time of Death		
	Physici		Catherine	L. Smit	t h				A	Month Ugust	2°0,	2007	7:35PM		
	/Medio Examín		4a. Facility Name (If not institution, gi	ve street and number)			4b. City, Town, or	Location of	Death		4c. Cou	inty of Death			
	CAdmin	e.	Caroline Nurs	ing Home			Dent	on			Ca	rolin	e		
	Funeral		5. Social Security Number 6.	Sex 7. Ag	e (In yrs. last birtho	day)	If Under 1 Year Months Days	If Under 2	4 Hrs. 8.	Date of Birth	Year)	9. Birthp	lace (State or Foreign try) Iand		
в	Director		219-05-8921	1 M 2 TO F	93 yr	S.	Month's Days	110013	F	eb. 20	, 191	4 Mary	land		
	P .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	or Lo	postion					1	0d. Inside City Limits		
	anyla shov	<u>_</u>	MD Carol	ino									1 ☐ Yes 2 ☐ No		
	188-1	ecto		THE		<i>-</i>	nton			1	Oc Citizon	of What Cour			
	with t	吉	10e. Street and Number 520 Kerr Aven				10f. Zip Code	() ()				d Sta			
	within 72 hours atter deeth with the Maryland ene. then "natural", or Items 23a or 28a-f show the Madical Evarning round by midiliari at	by Funeral Director		12. Was Decedent	Ever in ILS	13.1	1	629	in? (Specify			Race - Americ			
	ltem Item	un.	11. Marital Status t ☐ Never Married 2 ☐ Married	Armed Forces?	No.	13.	Was Decedent of H If Yes, specify Cuba	in, Mexican,	Puerto Ric	an, etc.)		Black, White,	etc.		
21215-0036	urs af	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 24 ☐ No	Specify:			Spe	ecify: W	hite		
9	2 hou	ted	15. Decedent's E	ducation	16a. D	ece	dent's Usual Occup	ation	af wasting		18b. Kind o	of Business/Inc	dustry		
215	hin 7	Completed	(Specify only highest gi	College (1-4or 5	1		kind of work done of DO NOT use retired	during most	or working		0	**			
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b	e filed al Hygid I other vent,	Be (17. Father's Name (First, Middle, Las	t)						irst, Middle, M					
/a	10a. State 10b. County 10c. City, Town or Location 10c. City, Town or Location 10d. Zip Code 10d. Zi							нет	en H	opkin	s La	ne 			
Maryland	2 sho and I is ma		19a. Informant's Name/Relationship				ng Address (Street				-				
	and 2 palith n 27 i		Upper Shore Ag	ing/Guaro				r Rd.							
ore	uges 1 nt of He Hiter or oth		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)								Date 20c. Location · City or Town, State				
Ĕ	Pages ment of the ant: If its ury or o			1XD Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bloomery Cemetery 08/24/07 Federalsburg, M											
Baltimore,	permit. Pa Departmer Important any injury		21. Signature of Funeral Service Lice	ensee		22	2. Name and Addre	ss of Facility	Fram	ptom	Fune	ral H	ome, P.A.		
	20239		Caristine	M. Coa	le		l6 N. Mai					ID 2163	Approximate		
			23a. Part1. Enter the disease, or conshock, or heart failure. List on	nplications that caused y one cause on each li	ne.			W			est,		Interval Between Onset and Death		
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Chro	UIC	K	ena	1 /	21/1	re		L	rans		
	/Medical Examiner		1 Suning in Gozin,				C	/							
		-	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):												
	ted	들	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									-			
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89	certificate nding phys use as the	Physician/Medic													
Вох	nding use	N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		2.	70				23d.	Date of delive	•		
ă	death of atten	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pregnant a	2 ☐ Fetal death t time of death		⊒Ectopic pregnancy ⊒ Other (specify)					Month	Day Year		
P.0	that the ed by the detache	hys	9 🗆 Unknown	9 Unknown											
	res tha signed I be det		Part II. Other significant conditions	contributing to death b	out not resulting in t	he u	inderlying cause giv	ren in Part I.					he cause of death?		
Ď		ed k	Demen	The						1 □ Ye	s 2 ⊡ √N	io 3∏Prot	pably 4 Unknown		
Records,		Completed by								24a. Was a autops	n 2	4b. Were auto	psy findings available mpletion of cause of		
Re	0 4 0	E								perform	ned2	death?			
Vital	ician: Th certificate rector, pag	40	25. Was case referred to medical					26. Place	of Death (C	heck only on					
>	S P	To B	examiner?	Hospital: 1 Inpatio	ent 2 ER/Outp	atier	nt 3□ DOA Oth	er: 4 vur	rsing Home	5 🗌 Reside	ence 6 🗆	Other (Specia	'y)		
0	To the state of th							y at k?	280	I. Describe ho	w injury o	ccurred			
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Division	er de recto	Certification:	3 Suicide 6 Could not 4 Homicide determine	d 289. Place of in	jury - At home, fam tc. (Specify)	n, st	reet, factory, office		28f	. Location (St City or Town	reet and N n, State)	umber or Aura	al Route Number,		
	itat or irs afte raf Dir led in l	Ce							11.1						
	To the Hospitet or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1	Medical	(Check only 2 Madical Ex	Physician: To the best aminer: On the basis of	of examination and/	deat or in	th occurred at the tire ivestigation, in my control	me, date and pinion, deat	d place, and h occurred	I due to the ca at the time, d	ause(s) and ate and pla	d manner as s ice, and due t	stated. o the cause(s)		
	the hin 2, the f	Med	one)	and manner st	ated.		29c, Licens	e number		2	9d Date si	igned (Month,	Dev Year)		
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			June	100	الوت	4	117 2	060	10 6		0 4		7127		
			30. Name and address of person wh	o completed cause of	geath (Item 23a) (T	уре.	Y) M	>AH	2-7	Se	10	Uto	W 450		
	C+	ate	31. Date filed (Month, Day, Year)	32 Regist	rar's Signature	0	0	7115		0 -1			· , , c. c.		
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07-06224		Please	Type or Print in Black Indelible Ink. Ensure All Copies Are L	_egible.
John P. Schoder			State of Maryland / Department of Health and Mental Hygiene	
	1- For State Registrar	е	Certificate of Death	Reg. No.

	1- For State Registrar	Certin	ficate of Death	, ,	Reg. No.	27111			
Physician/	Decedent's Name (First, Middle,La	st)		l M	ate of Death lonth Day	Year 3	Time of Death		
Medical Examiner	JOHN PAUL			Αι	ugust 12, 2007		1150 hrs		
	4a. Facility Name (if not institution, gi Rt. 222 & Oakwood Road		4b. City, Town, or Loc Port Deposit	ation of Death		County of Death			
Funeral	5. Social Security Number 6. S			If Under 24Hrs. 8.	Date of Birth (MM/D		place (State or		
Director		KM 2 F 33	Months Days	Hours Min.)7/23/1974	Foreign	try) DE		
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auy	10a State 10h County	nester 10c. City, To	own or Location	,	1, .		0d. Inside City Limits		
Maryland 28a-f show 1 at once. ector	PA NEW G	ARDEN TO	UGHKENAMON	* -	1 Yes 2 X No				
hoursafter death with the Maryland naturial", or items 23a or 28a-f sho Examiner must be notified at once.	10e. Street and Number 1242 NEWARK ROA	AD.	10f. Zip Code 19374	1 -	10g. Citize	en of What Countr USA	y?		
with the same and if	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispan	nic Origin? (Specify	Yeś oż No- 1	4. Race - America	n Indian, Black,		
r death with or items 22 must be no	1 Never Married 2 Marrie	d Armed Forces?	If Yes, specify Cuban, Months 1 Yes 2 No si	exican, Puerto Rica		White, etc. WHITE			
staffer uiner		lf Yes, Give Year or Dates:				Specify:	l. alm.		
5-0036 led within 72 hoursafte Hygiene. other than "natural", the Medical Examinar Completed by	15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or 5+)	6a. Decedent's Usual Occupation during most of working life. DO		. Tob. KI	nd of Business/Inc	iustry		
136 hin 72 e. than edical	12	college (1-4 of 51)	MACHINE OPERA	TOR .		MANUFACT	TRING		
5-0036 ed within 72 hour officere. stylegiene. other than "natt the Medical Exau	17. Father's Name (First, Middle, Las	t)			st, Middle, Maiden S		SICING		
21215-C uld be filed v Memal Hygi marked oth cevent, the I o Be Co	JOHN E. SCH	RODER	L	INDA HEND	RICKSON				
MD 21215-0036 12 should be filed within 72 th and Mental Hygiene. To Tis instricted other than " unnatic event, the Medical To Be Complet	19a. Informant's Name/Relationship	Type, Print)	19b. Mailing Address (Street ar						
ages 1 and 2 shount of Health and 1 it. If item 27 is until other traumatic	LINDA SCHRODER 20a. Method of Disposition	Look Die	23283 LIBERTY nce of Disposition (Name of cemetr			PA 17229 ocation - City or T			
or Health	1 X Burial 2 Cremation 3		matory or other place)	ery, , Da	le 200. Li	ocation - Gity or T	own, State		
timent tant:	4 Dopnation 5 Other Specific	71	ONGWOOD CEMETER		2007 KE	NETT SQU	JARE, PA		
Baltimore, M permit Pages 1 and 2 Department of Health Important: If item 2 injury or other traun	21. Sign t e of Funeral Lice	71	22. Name and Address of KUZO & GR	TECO FUNE	RAL HOME		on the same and the same and		
Physician	23a. Part I. Enter the disease, or com	pplication hat caused the death. D	o not enter the mode of dying, suc	STUTE SILE	pira ory arres , shoo	mp ⊆ 11711 ×, or hem	Appröximate Interval		
/Medical	failure. List only one cause on	each line. a. Multiple Injuries	, .				Between Onset and Death		
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ial ial	UNPENDED	X #3, perME, g870, 8/	31/07 TT						
	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregna	ncy	Ectopic pregnancy		. Date of delivery Month Da	ay Year		
K 68 n certif ending use as	past 12 months?	1 Live birth 4 Pregnant at time of death	_	Ectopic pregnancy		WIOTIET DE	,,		
). Box 687 the death certifi by the attending ched for use as t Physician/	1 Yes 2 No 9 Unknow	g Unknown	- Cator (c)	573344557					
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cords, law requir has been s 2 should l	1				24a. Was an autopsy	prior to co	opsy findings available impletion of cause of		
Records, The law requires firete has been sign page 2 should be Completed				,	performed? 1 ✓ Yes 2 No	death?	2 No		
Vital Rec ysician: The his certificate director, page o Be Con	25. Was case referred to medical examiner?		12.	Death (Check only	one)				
f Vite Physic or this craffice	1 ✓ Yes 2 No		Woutpatient 3 DOA	ner Nursing Ho		nce 6 🗸 Other:	Scene		
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Division o septral or Attending hours after death. meral Director: Afte y filled in by the fune Certification:	3 Suicide 6 Could no determin	ot be	e, farm, street, factory, office build		or Town, State) 222 & Oakwood				
Division Hospital or Attent 44 hours after death returnal Director: rely filled in by the	4 Homicide 29a. Certifier	cian: To the best of my knowledge							
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To with To con	29b. Signature and title of certifier	Grid Harrier Stated.	29c. License n	umber	29d. D	Date signed (Moni	th, Day,Year)		
	(Chest 2		O.C.M.	E.	Augi	ust 13, 2007			
N	30. Name and address of person who		•	MD 24204					
RI		32 Panietrar's Signature	11 Penn Street, Baltimore	:, IVIL) Z IZUI					
State Registrar		2007 32. Raistrar's Signature	More						

				1 - State Registrar	State of I	Maryland		irtment of h	lealth and N Death	/lental Hy	giene (
				Decedent's Name (First, Middle, Las	t)					2. Date of De	ath		3. Time of Death
	П	Physici		Marsha Ann Sci	roeder					August	Day 1.3	Year 2007	11:03 P ^M
		/Medic Examin		4a. Facility Name (If not institution, give		er)		4b. City, Town, o	or Location of Death			unty of Death	11.031
		LXuiiiii		Harford Memor:	ial Hosp	ital		Havre	de Grace	!	F	larford	
		Funeral		5. Social Security Number 6. Se	x 7.	Age (In yrs. la	st birthday)	If Under 1 Year Months Days		8. Date of Bit (Month, Da	th Vear	9. Birthp	lace (State or Foreign try)
		Director		219-42-0515	☐M 2[XF	63	Yrs.	MOTHIS Days	Hours Will.	April			yland
		D		Usual Residence of Decedent 10a. State 10b. County		100 City	Town or Loc	nation				1	0d. Inside City Limits
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Σ		with t	늅					10f. Zip Code	•		rog. Citizen		itry ?
0		eath	Funeral	7 May Street	12. Was Decede	ent Ever in U.S.	13 V	2190	L Hispanic Origin? (Sp	necto Yes or No	n 14.	USA Race - Americ	an Indian
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Õ	336	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date		1	☐ Yes 21XNo	Specify:		Sp	есіfy: Wh	ite
230	ŏ	within 72 hours after death with the Maryland ene then *neturel; or items 23a or 28a-f ehow the Mudical Examiner (* 11st be notified at	ted	15. Decedent's Ed			16a. Deced	ent's Usual Occu	pation		16b. Kind	of Business/In	
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	21	giene giene	Completed	12		,	Mach	ine Oper	ator		P1a	stics	
	멀	al Hy al Hy f oth	Be (17. Father's Name (First, Middle, Last)					18. Mother's Nam	ne (First, Middle	, Maiden Sui	mame)	
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2	lar	2 shd and is m		19a. Informant's Name/Relationship (7					and Number or Ru				Code)
$\overline{\mathbb{X}}$	e)	l and fealth im 27 her ti		Raymond Schroeder	/Husband	20h 9la		ay Stree sition (Name of	t, North	East, M) 1 ion - City or To	Chito.
8/13/0	ŏ	in of the state of		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐		ate cer	metery, crem	natory`or other pla		16-2007		•	
	altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heatih and Mental Hygiene. Importent: If Item 27 is marked other then "neturel; or Items 23a or 28a-1 ehow any injury or other treumatic event, the Medical Exporter rest be notified as once.		4 Donation 5 Other (Specify 21. Signature In al Servin Licen		R.T.		Funeral Name and Addre	l Home, P	.A.	Risin	g Sun,	Maryland
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		Physician		Immediate Cause (Finaf disease or condition	. (OPD							Onset and Death
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	×	nding puse as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			-			23d	. Date of delive	эгу
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(1)	0	t the by the	hys	9 Unknown	9□ Unknow	n ————				,			
Ď	S, F	w requires that the death certific been signed by the ettending I should be detached for use as	by P	Part II. Other significant conditions of	ontributing to deat	th but not resul	ting in the ur	nderlying cause gi	ven in Part I.	23e. Did	tobacco use	contribute to t	ne cause of death?
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5	Ä	sicien: The lav certificate has rector, page 2	ĕ							perf	ormed? 200 No	death? 1 ☐ Yes	·
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20	of V	Physician: this certific ral director,	2	1 ☐ Yes 2 No	Hospital: 1 X fnp	atient 2 🗆 E	R/Outpatien	I SU DOA		ome 5 Res	idence 6	Other (Specif	(y)
0,		ing Phys After this funeral di		27. Manner of Death 1 Natural 5 Pending	28a. Date of I (Month,	Injury Day Year)	28b. Time of Injury	28c. Inju	ry at ork?	28d. Describe	how injury o	ccurred	
	Sio	Attending ir death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 No				
	Division	or At offer of Direct in by	Certification;	4 ☐ Homicide determined	200. Flace UI	Infury - At hon , etc. (Specify)	ne, farm, stre	eet, factory, office		City or To	(Street and N iwn, State)	lumber or Hura	al Route Number,
		ours a	3 Ce	29a. Certifier 1 Cartifying Ph	ysician: To the be	est of my know	ledge, death	occurred at the t	me, date and place	, and due to the	causa(s) an	d manner as s	tated.
		To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edicai	(Check only 2 Madical Examone)	iner: On the basi and manner	is of examination	on and/or inv	estigation, in my	opinion, death occu	rred at the time	, date and pla	ace, and due to	the cause(s)
_		within To th comp	Me	29b. Signature and title of certifier		_		29c. Licen	,		29d. Date s	igned (Month,	Day, Year)
				· Well	\wedge	$\wedge D$		Do	06327	20	8	1/4/	2007
				30. Name and address of person who	completed cause	of death (Item :	23a) (Type,		CSAPEA		2 R	FI AT	RAND
		6		0003	LUARW			100 (1)	CONVO	1010	, 12		21018
	2	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 6	2007 32. R	istrar's Signati	K 4	back					

		-	For State Registrar	State	of Marylan	-	artmen <i>rtificat</i>			and Mo		giene 10g. No U		27803
			Decedent's Name (First, Middle, L	ast)							2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physici		PATRICIA ANN	SMITH							August	12, 2		10:00 p ^M
	/Medio Examin		4a. Facility Name (If not institution, g	ive street and n	ımber)		4b. City,	Town, or	Location o	of Death		4c. Count	ty of Death	
			Shady Grove Adv	ventist	Hospita	1		ckvi					tgome	
	Funeral Director		5. Social Security Number 6. 579-34-6410	Sex 1☐M 2X F	7. Age (In yrs. 77	last birthday) Yrs.	Months	1 Year Days	If Under a	Min.	8. Date of Birth (Month, Day 04-24-1	(Year)	Cou	place (State or Foreign ntry) iana
	9		Usual Residence of Decedent		10a Cit	y, Town or Lo								10d. Inside City Limits
	ehow	_	10a. State 10b. County											1 XYes 2 No
	28a-f	Directo	Maryland Prince 10e. Street and Number	George	's Hy	attsvi	10f. Zip	Code				10g. Citizen of	What Cou	intry?
	with t	5	4707 66th Plac	20				784				U.S.A		
	eath	Funerai	11, Marital Status	12. Was De	cedent Ever in U	.S. 13.			spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)		ace - Amer	ican Indian,
9	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23e or 28e-f show event, the Modical Exercical must be notified at	F	1 Never Married 2 Married	Armed I	2 🛛 No		If Yes, spe		n, Mexican Specify:		tican, etc.)		ack, White	
3	raif, o	ρ	3 XWidowed 4 ☐ Divorced	If Yes, C Year or	Dates:		1 1 1 1 1 1 1 1	2 <u>A</u> 1 NO	эреспу.				ify: Wh:	
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V	within 72 ene. than "nay	m	Elementary/Secondary (0·12)	College	(1-4or 5+)	1	keepe		"			Dr. D	ona1d	l Cohen
V	e filed v al Hygie other t vent, th		17. Father's Name (First, Middle, La	st)		DOOR	Keepe	-1	18. Mothe	er's Name	(First, Middle,			· oonen
yidild	uld be d Aental I rked o tic eve	o Be	Lloyd McDonald	•					Fet	rn Gr	600			
	should nd Men marke umatic	ျင	19a. Informant's Name/Relationship	(Type, Print)		19b. Mail	ing Addres	s (Street			Route Numbe	er, City or Tow	n, State, Z	ip Code)
2	and 2: eelth ar n 27 is		Sue Evans - Da	ughter		4707	66t	h Pl	ace,	Hyat	tsville	e, Mary	1and	20784
baltimore,			20a. Method of Disposition			Place of Disp cemetery, cre	osition (Na	me of other plac	(e)	D	ate	20c. Location	n - City or T	Town, State
Ē	Page nent c int: If		1 XBurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		m State MD	Vetera	ans Ce	meter	у	08-17	7-2007	Che1t	enhan	, Maryland
5	permit. Pages Depertment of H Important: If Its any injury or of	1	21. Signature of Funeral Service Lice	ensee	0-0-0	2 5	2. Name a			-				imore Ave.
٥_	82559		23a/ Part1. Enter the disease, or or		17013						e, P.A.		tsvi	Approximate
7	Physician /Medical Examiner	ner	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a Due t	CELEU NO (or as a consec	quence of):	SLV	UM	AC	CCID	O(N)			Onset and Death
68/60,	ificate be executed g physicien and as the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due t	o (or as a consec	quence of):								1.11
O. BOX	res that the death certifica igned by the attending ph be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	outcome of pregn birth 2 Fet gnant at time of known	aldeath 3	□Ectopic p		<u></u>				Date of deli Month	very Day Year
rds, F	quires tha n signed uld be del	d by P	Part II. Other significant condition HYDER TENSI	UN	SH051	5 }	underlying		PIDG			-		the cause of death? obably 4 Unknown
II Kecords,	The law requires that the sete has been signed by the page 2 should be detache	Completed	PUMOMAY	EMIS	OUIM	,					24a. Was auto perfo 1 \(\text{Yes} \)		b. Were au prior to death? 1 \(\sum Yes\)	topsy findings available completion of cause of 2 \square No
<u> </u>	clan: ertific ector,	Be	25. Was case referred to medical examiner?	Hospital:	,			Ott	or.		Check only o			
5	Physic this c	ြို	1 Yes 2 No 27. Manner of Death	19	Inpatient 2	ER/Outpation 28b. Time		OA	4 N		me 5 Resi			cify)
<u></u>	Jing F	ion	1 Natural 5 ☐ Pending	(M	onth, Day Year)	Injury	м	28c. Injui Wor	rk? Yes 2		200. 00001100	now injury coo		
Division of Vital	the Hospital or Attending Physiclen: The law willin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Pla	ce of Injury - At I	nome, farm, s					28f. Location (City or To		mber or Ru	ıral Route Number,
	the Hospital or will in 24 hours after for the Funeral Director completely filled in I	edicai (29a. Certifier Certifying (Check only one) Certifying	kaminer: On the	the best of my kr basis of examinanner stated.	nowledge, dea	ath occurre investigation	d at the ti	me, date a opinion, de	nd place, ath occur	and due to the red at the time,	cause(s) and date and plac	manner as	s stated. to the cause(s)
2	with the Toth comp	Me	29b. Signature and title-of certifier	mb	man	/		1)5	3 3 (201	29d. Date sig	STI	m, 2007
8	90		30. Name and address of person w	M Ali	VENVE,	JVIN		H,	SIL	WW.	PRINA	, M	p:2	0902
	St	trar	31. Date filed (Month, Day, Year)	32	. Registrar's Sign	iature								

State of Maryland / Department of Health and Mental Hygiene Kendrix Nakia Thomas 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 9, 2007 0125 hrs าl Examiner Thomas Kendrix Nakia 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Clinton 6705 Surratts Road If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign New Orlean Months Davs Hours Nov. 26 1978 Director 439-35-6532 28 1 XM 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Y Yes 2 No 23a or 28a-f show notified at once. Anne Arundel Md Edegewater Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural" are itages 72s. - 120. - 6-1-1 Director 10g, Citizen of What Country? 10f. Zip Code 10e Street and Number 303 Bay View Drive 21037 U.S.A. Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 2 X Married Never Married 2 X No Yes Specify: Black If Yes, Give Year Divorced 1 Yes 2 X No specify: 3 Widowed ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4 or 5+) the Medical 21215-0036 Private 12th Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) tranmatic event, Be Harrison Thomas Sharon H. Hamilton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 459 Orange Street S.E. Washington, DC 20032 Nikkisha L. Mason-Thomas/Wife 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a, Method of Disposition Baltimore, crematory or other place) XBurial 2 Cremation 3 Removal from State Mount Olivet Cemetery 8/16/2007 Washington, DC Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral South Legisee J. B. Jenkins Fulleral home 7474 Landover Road Landover, Maryland 20785 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart Approximate Interva **Physician** Between Onset and failure. List only one cause on each line Medical Death a. Gunshot wound of abdomen Immediate Cause (Final disease ∡aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): enurs: Enter Underfutho Course (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial - tran sician/Medical AMENDED UNPENDED 68760, 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Live birth Fetal death 3 Ectopic pregnancy Day past 12 months? Pregnant at time of death 5 Other (Specify) Box 1 Yes 2 No 9 Unknown g Unknown P 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö ě 1 Yes 2 No 3 Probably 4 Unknown ۵. Completed Records, s been s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has death? performed? ✓ Yes 2 No 1 V Yes page 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical director of Vital Hospital: Other₄ Nursing Home 5 Residence 6 V Other: Scene Inpatient ER/Outpatient 3 DOA After this 1 ✓ Yes No 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work 27. Manner of Death Aug 9, 2007 Certification Subject shot 0051 hrs Natural 1 Yes 2 ✔ No Division Pending death. Director: 2 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 6616 Surratts Road, Clinton, MD determined (Specify) Single Family 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. August 9, 2007 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD. 31. Date filed (Month, Day 32. Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 2 137 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hall Road 3057 JOUR 11/0 8. Date of Birth (Month, Day, Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign XX M 2□ F **Funeral** Months Days Hours Min. 022-24-8147 75 Director 1931 Massachusetts Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he activated once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Anne Arundel Riva 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3057 Tudor Hall Road 21140 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1.05 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. NXYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: White þ 3√Widowed 4 □ Divorced 1952 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Transportation U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minard Evans Tupper, Sr. Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nina Jean Tupper / Daughter in law117 Edgemere Drive Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State XIX Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) Crownsville Vet. Cem. 8/14/2007 Crownsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. Mil 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Anset and Death Immediate Cause (Final disease or condition resulting in death) DMA Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknown ils certificate has been signed director, page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 22 No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) Certification: To After this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8

State

Registrar

30. Name and adds

31. Date filed (Month, Day,

Year)

AUG 1 4 2007

Rd Jule 300 Anneps

ess of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician 10:58 P M 2007 Aug White Mary /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Southern Maryland Hosp Clinton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthdav) 5. Social Security Number 6. Sex Funeral Months Days 1 □ M 2 F 306-22-7589 83 7-8-1924 Indianapolis IN Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Director MD Prince George's Capitol Heights 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20743 USA 4703 Heath Street Funeral permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s any Injury or other traumatic event, the Medical Examiner must 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※☐ No If Yes, Give Year or Dates: 14. Race · American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No Black Specify. Specify: ģ 3 ☐ Widowed 4 🛱 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Military Pay Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Mary Anderson Beaven James Henry ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2901 West Grove Upper Marlboro MD 20774 Lois A. Williamson -Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/13/2007 Suitland Maryland Lincoln Memorial 22. Name and Address of Facility Pope Funeral Home 21. Signatore of Funeral Service 5538 Marlboro Pike Forestville Md 20747 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final guen way! 150 nation disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and buriai-trai Due to (or as a consequence of): attending physician Completed by Physician/Medical as the IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death in the past 12 months?

1 Yes 2 No
9 Unknown 2 Fetal death 3 ☐ Ectopic pregnancy Year Month Dav 5 ☐ Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24a. Was an autopsy

Physician

Baltimore, Maryland 21215-0036

filled in by the funeral within 24 hours after death To the Funeral Director:

Division or Vital Records, P.O. Box 68760,

Medical Certification: To Be

Horzatersion 26. Place of Death (Check only one

1□ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case regred to medical examiner? 27 No 1 ☐ Yes 27. Manner of Death

5 ☐ Pending investigation

6 ☐ Could not be determined

1 Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? Date of Injury 28b. Time of (Month, Day Year) Injury

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

(Check only

Natural

2 Accident

3 ☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Surratts Road G. Nachnouni 7503

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year) 4 2007

death

ro the Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Ethel Woods 9:00 a 2007 3, August /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Pineview Future Care Nursing Home Clinton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1□M 2√2F 89 419-32-8695 Director 23, 1917 Pittsburgh, P.A Usual Residence of Decedent 10c. City. Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Prince Georges Landover Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1213 Ivy Club Lane #2223 20785 United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛂 No Specify: Black <u>Ş</u> 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within ealth and Mental Hygiene. n 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Dietetican Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (ပ John Brown Anna Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trau 1213 Ivy Club Lane #2223 Landover, Md. 20785 Alfred Crochan, Jr. / Son Pages 1 ament of He 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug. 9, 2007 Alexandria, Va. Metropolitan 21. Signature Funeral Service License 22. Name and Address of Facility Alexander S. Pope P.A. 5538 Mariboro Pikė/Forestville, Md. 20747 23a. Patt1. Enter the disease shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, last only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final of There sclene his **Physician** disease or condition resulting in death) Jeans /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and the buriat-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the a 9 Unknown 9 Unknown been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed 2 No 1☐ Yes 2☐ No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation 1 ∏Yes 2 ∏No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Wedical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08-07-2007 D45365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m.D 11701 livings for RILL 101, fort CAShing ton MB 20741

State Registrar 31. Date filed (Month, Day, Year)

AUG 1 4 2007

SipARous 32. Registrar's Signature

			1 - For State Registrar	State of Maryla	•	irtment of H tificate of L			ene .	1011		
	Dhunisi		Decedent's Name (First, Middle, La	st)				2. Date of Death Month		3. Time of Death		
	Physici /Medi		Peter Wood					AUgu:	st 14,200			
1	Examir	ner	4a. Facility Name (If not institution, giv SALISBURY REHAE		G CENTER	4b. City, Town, or SAL I	SBURY, I	MD. 21804	4c. County of Deal	COMICO		
	Funeral		5. Social Security Number 6. S	ex 7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year) 9. Birt	thplace (State or Foreign		
	Director		157-40-2230 Usual Residence of Decedent	77	7 Yrs.			April 1	9,1930 Eng			
	yland how		10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits		
	8a-f	cto	Md Worcest	er E	Berlin			T-		1X Yes 2 No		
	with ti	Funeral Director	10e. Street and Number 8 Hidden Lake Co	urt		10f. Zip Code 21811)g. Citizen of What Co USA	ountry?		
	deeth	nera	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13. V	Vas Decedent of Hi	spanic Origin? (S	Specify Yes or No-	14. Race - Ame			
36	72 hours after deeth with the Maryland naturel', or Neme 23a or 28a-f ehow lical Examinan must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Yes, specify Cubar	Specify:	to rican, etc.)	Specity: Wh			
21215-0036	72 hou	eted	15. Decedent's Ed (Specify only highest gra		(Giva	lent's Usual Occupa kind of work done d	luring most of wo	rkina 1	6b. Kind of Business	findustry		
121	within 6ne. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired,)	,9	0			
	Hygid other	Be Co	17. Father's Name (First, Middle, Last,	· · · · · · · · · · · · · · · · · · ·	Fiec	tronic En		me (First, Middle, M	Communica Naiden Sumame)	tions		
/lan	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, ITE Mental Mental Communications and the Men	To B	Stanley Wood				Kate W	isbey				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Iteme 23a or 28a-1 show eny injury or other treumatic event, to Medical Examinat must be notified at once.		19a. Informant's Name/Relationship (Simon Wood (son)									
Je,	of Health of Health I from 27 r other tr	- 95	20a. Method of Disposition		b. Place of Dispos				Oc. Location - City or	Town, State		
Baltimore,	Pages tment of I tant: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	n) Ca		open Crem			rankford,			
Bal	permit Pages Depertment of h Important: If its eny injury or of		21. Signature of Fun and Service Licer	/				ne Burbage Berlin, Me	e Funeral d. 21811	Home		
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Box	death certificate be executed ettending physician and I for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year			
P.O.	that the de ted by the e	hys	9 Unknown	9□ Unknown								
	w requires that been signed I should be det	þ	Part II. Other significant conditions of	ontributing to death but not	resulting in the un	derlying cause give	n in Part I.		acco use contribute to s 2 ☑ No 3 ☐ Pr	the cause of death?		
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of	Phys this ral dii	5	1 ☐ Yes 2 ☑ ★10 27. Manner of Death	Hospital: 1 Inpatient 2			4 - Iwursing F	fome 5 Resider	nce 6 Other (Spe	city)		
ion	Attending Ph ir death. ector: Affer th by the funeral	ation	1 Statural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) Injury	28c. Injury Work M 1 ☐ Y	? ′es 2∐No	200. 0000100 1101	· injury occurred			
Division	5 # # S	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of City or Town, State)							ural Route Number,		
	To the Hospital or A within 24 hours after To the Funaral Direction completely filled in by	Medical C	29a. Certifier 1 Certifying Ph	ysician: To the best of my liner: On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred at the time estigation, in my op	e, date and place inion, death occu	a, and due to the car arred at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)		
	To the Within To the comple	Me	29b. Signature and title of certifier	and mariner stated.		29c. License	number	29	d. Date signed (Mont	h, Day, Year)		
		- 3	1000	Then		0.	2879	19	8/15/07)		
	BAIZ		30. Name and address of person who WILLIAM ROBINS	completed cause of death (I	Item 23a) (Type, F	SALISB	URY, MD.	21804				
	State 31. Date filed (Month, Day, Year) Registrar AUG 1 6 2007 32. Fegistrar's Signature											

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/largaret Denise \		shington State o	of Maryland / D		ment of He icate of De		d Mental	Hygiene	21	107 2331
	B	egistrar		Certin	cate of De-	alli		2. Date of Deat	eg. No.	3. Time of Death
Physiciar Medical Examine	er	I. Decedent's Name (First, Middle,Last) Margaret	Denise		Wash	ingt	on	Month August 18	Day Year , 2007	1304 hrs
	•	4a. Facility Name (if not Institution, give	street and number)		4b. Cit	y, Town, or	Location of De	ath	4c. County of D	
		8301 Ashford Boulevard				urei			Prince Geo	
Funeral Director		5. Social Security Number 6. Sex 229-02-6010		yrs. last!		nths Day		⁄lin	1963	Birthplace (State or Country) irginia
, Al		Usual Residence of Decedent 10a. State 10b. County	100	c. City. To	wn or Location					10d. Inside City Limits
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death-with the Maryland frient of Health and Mental Hygiene. Itani: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	1			,,		_ 1				1 X Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death-with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	٤	Maryland Prince	George		Laur 10f.	Zip Code		1	0g. Citizen of What	Country?
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of ing Ph	⊢ }	27. Manner of Death	28a. Date of Injury (Month, Day, Year	.) 2	8b. Time of Injury	1 1	ury at Work?		how injury occurred	
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Hosp 24 ho Func		29a. Certifier (Check only 1 Certifying Physicia	an: To the best of my k	nowledge	, death occurred a	t the time,	date and place,	and due to the cau	use(s) and manner a	s stated.
Division of Vital Records, To the Hospital or Attending Physician: The law requirements after death. To the Funeral Director: After this certificate has been seen sempletely filled in the funeral director, page 2 should	Medical	one) 2 Medical Examiner	On the basis of examir and manner stated.	nation and	/or investigation, i			ed at the time, date		
FSFS	ž	29b. Signature and title of certifier	1 /				nse number		1	(Month, Day, Year)
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	ı	30. Name and address of Arson who o			3a)					
DB I	j	Jack Titus MD. Deputy	Chief Medical Exa		111 Penn S		altimore, MD	21201 		
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36	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show imatic event, th. Medical Examiner must be notified at	by F	1 □Never Married 2 □ Mar 3 □ Widowed 4 ☑ Divorced	If Yes, Giv	/e		1 □ Yes 2 🛛 N	o Specify	iy:			Specify:	Bla	ck	
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0	Jing Ph L. After th funeral		27. Manner of Death 1 Natural 5 Pendi	28a. Date	of Injury th, Day Year)	28b. Time o	f 28c. In	jury at		28d. Describ	e how ir	njury occurre	ed		
<u>ö</u>	Attendir death. ctor: A	atic	2 ☐ Accident invest	gation	, , , , , , , , , , , , , , , , , , , ,	,,		Yes 2	□No						
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	e Hospital 24 hours a e Funeral I letely filled		29a. Certifier 1 Certifyi (Check only 2 Medical	ng Physician: To the Examiner: On the b	best of my know	wledge, deat	h occurred at the	time, date a	and place,	and due to t	he cause	e(s) and mar	ner as sta	ated.	
	the Hos in 24 ho the Fun tpletely	Medical	one)	and man	ner stated.						io, uale	апа ріасе, а	110 000 10	ine cause(s)	
	To the To the To the Romplet	Σ	29b. Signature and title of certific					nse number				Date signed			
ì	16)		(anisame)	, wanger.	OMO		D 00	165£	11:		W	eust	1013	root	
	100		30. Name and address of persor	who completed caus	e of death (Item										
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DHMH 17 Rev 1/2001

AUG 1 5 2007

Baren D. Speck

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 10, 2007 1612 Gertrude Ann WEISS 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth Months | Days | Hours | Min. | Mapth, Pay 5. Social Security Number 298-09-3948 7. Age (In yrs. last birthday) 92 Yrs. 9. Birthplace (State or Foreign AMPTPayl Carl 915 P61 amd 1 □ M 2 □XF Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 XNo MD Montgomery Potomac 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20854 U.S.A. 9806 Clagett Farm Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 Q No Specify. Specify: 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frieda Louis Zusman unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin Weiss 9806 Clagett Farm Drive, Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 D Other (Speqity) Beth DAvid Cemetery Aug. 13, 2007 Hollywood, FL 21. Signature of Funeral Service License 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Jach line. Approximate Interval Between 2 days Immediate Cause (Final Congestive Heart Failure: disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 🗖 No 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ♥Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an 2 No 1□ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be

Health attem 27 ls

ō Department o Important: If any Injury or

with the Marylar show r 28a-f shov notified at

Maryland 21215-0036

altimore,

Pages **→**

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burial-trar ng physician as the burial attending I for use as ed by the a page 2 filled in by the funeral director, Director: After

Division or Vital Records, P.O. Box 68760,

955

Examiner Physician/Medical þ Completed Be Certification: To 27. Manner of Death 2 Accident 3 ☐ Suicide 4 Homicide

29a. Certifier

in the past 12 months? 9 Unknown

25. Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No

5 Pending investigation

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

and manner stated. 29b. Signature and title of certifier

6 ☐ Could not be

29c. License number D37591

29d. Date signed (Month, Day, Year) August 10, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. Rajvanshi, MD 121 Congressional Lane, #400, Rockville, MD. 20852

State Registrar

Medical

31. Date filed (Month, Day, Year) AUG 1 5 2007



or A

24 hours a Hospital

within 2

			For State Registrar	State of Ma	-		rtificate of I			ieniai n		. No.	7	.101
	Physici		1. Decedent's Name (First, Middle, Las KAREN L. YOUNG	•						2. Date of I Month	Death	Day Ye 2007	ar	3. Time of Death 7:40A
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Town, or	Location	of Death	AUG.		4c. County of D	eath	7.4UA
	(1) 24: 2		8170 FENWICK 5. Social Security Number 6. Se	CT.	(In yrs. last birl	thdav)	I.AURE.]	If Under	r 24 Hrs.	8. Date of I	3irth	PRINCE	Birthol	ace (State or Foreign
	Funeral Director		578-70-2954	□M 2FOYE		Yrs.	Months Days	Hours	Min.	(Month, 6/6/t	Day, Y	ear)	Count	try) HINGTON , D
	yland how at		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loc	cation						10	0d. Inside City Limits
	death with the Maryland ems 23a or 28a-f show r must be notified at	Director	MD PRINCE 10e. Street and Number	GEORGES	LA	URI	EL 10f. Zip Code				100	. Citizen of What	Count	tv² Yes 2□No
	a or			_				0.77			109			.,,.
	ms 2;	Funeral	8170 FENWICK C	12. Was Decedent E	ver in U.S.	13. V	2070 Nas Decedent of H f Yes, specify Cuba		rigin? (Sp	ecify Yes or I	No-	U.S.A 14. Race - A	America	
136	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fui	1 □ Never Married 2 🔀 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2X N If Yes, Give Year or Dates:	0		r ves, specily Cuba I □ Yes 2□XNo	Specify		Hican, etc.)		Black, V Specify:		LACK
15-0036	n 72 hou n "natura ledical E	Completed	15. Decedent's Ed (Specify only highest gra-	de completed)		Deced (Give I	lent's Usual Occup kind of work done o	ation during mod	st of work	ing	16	b. Kind of Busine	ess/Ind	ustry
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and	be file ital Hy id oth	Be	17. Father's Name (First, Middle, Last)							•		iden Surname)		
5	should and Men marke	우	UNK . 19a. Informant's Name/Relationship (7)	voe. Print)	19b.	. Mailin	g Address (Street			H. JO			te. Zip	Code)
Ma	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		REV. DR. BARON		- 1		-					-		,
Baltimore,	a 0 .		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐				sition (Name of matory or other place			Date	_	c. Location - City		
Ĕ	Pages tment of it tant: If its ijury or o		4 □ Donation 5 □ Other (Specify)	CHESA		AKE CREI		8/13			BELTSVI		
ga	permit. Page Department of Important; If any Injury or once.	0 0	21. Signature of Funeral Service Licen	Towar	t		Name and Address ALL							L SERVICE, MD 2074
	Physician /Medical		23a. Part1. Enter the disease, or come shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a. MET		C 1	er the mode of dyin			or respiratory	arres/	t,	2	Approximate Interval Between Onset and Death 1/2 YRS.
	Examiner		Sequentially list conditions	h		.,.								
	ecuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):											
68/60,	ificate be executed g physician and as the bunal-transit	edical Ex	resulting in security East	d	consequence	or):								
O. Box 6	attendin for use	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23d. Date 23d. Date							23d. Date of Month		ery Day Year	
dS, F.	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions of	ontributing to death bu	t not resulting in	n the ur	nderlying cause giv	en in Part	1.		d toba □ Yes			ne cause of death?
records,	e law has b je 2 st	Completed								24a. W	as an itopsy	24b. Wer	r to cor	psy findings available npletion of cause of
Ta Ta	(0 17	e Co	25. Was case referred to medical					OF Disc	o of Doot	1 Ye:	s 2)			2 No
>	Physician: r this certific ral director,	To Be	examiner? 1 \(\sum \text{Yes} 2\sum \text{No} \)	Hospital: 1 Inpatier	nt 2□ER/Ou	tpatien	t 3 DOA Oth	or:				ce 6 Other (Specify	·/)
n or	eur aure		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		Time of njury	Wor	y at k?				injury occurred		
UIVISION	ne Hospital or Attending n 24 hours after death. ne Funeral Director; After bletely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ry - At home, fa . <i>(Specify)</i>	rm, str	M 1□ eet, factory, office	Yes 2□]No	28f. Location City or	n (Stre Town,	et and Number o State)	r Rura	I Route Number,
ם	Hospital of hours af Funeral D tely filled in		29a. Certifier 1 Certifying Ph	ysic)an: To the best on the basis of	f my knowledge	e, death	n occurred at the til	me, date a	and place,	and due to t	he cau	ise(s) and manne	er as st	ated.
	To the Hosl within 24 ho To the Fund completely i	l edical	one)	and manner sta		10/01/11	29c. Licens		Satir Occur	Tod at the till				
	To	Σ	29b. Signature and title of certifier	elle 1	1/11		DO8				290	1. Date signed (A	-	ouy, rout/
0	(15)		30. Name and address of person who	//		(Type,	Print)		مر شرالال	יי מת	201	-11010	•	TT MD 207-
		to-	31. Date filed (Month, Day, Year)	SINGER, MD			REENWAY	CEN	1.T.E.K	DK.#	20	O GKEEN	VDE.	11,MD 70
	Sta Registi		AUG 1 3 2007	Siere .	r's Signature	the	•							

State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate Certificate C	f Death	Reg	. No.	2101
Physici	an/	Decedent's Name (First, Middle,Last)		2. Date of Death Month	Day Year	3. Time of Death 0009 hrs
f dical Exami		Jeannette Eva Yourman 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	August 17,	2007 4c. County of Death	
		9717 Old Fort Road	Fort Washington		Prince George	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hi	_	(MM/DD/YYYY) 9. Bir	thplace (State or an Rhode
Director		035-28-5128 1 M 2 X F 63 Yr	Months Days Hours Mi	^{n.} Jan.13,	1944 co	untry) Island
,	ļ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ation			10d. Inside City Limits
d now any e.		Maryland Prince George Fort Wash:				1 Yes 2 X No
Aaryland 28a-f show		10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cou	ntry?
with the Maryland ns 23a or 28a-f she be notified at once	Dire	9717 Old Fort Road	20744		U.S.A.	
5 72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once		11. Marital Status 12. Was Decedent Ever in U.S. 13. W	as Decedent of Hispanic Origin? (\$ Yes, specify Cuban, Mexican, Puerl		14. Race - Amer White, etc.	ican Indian, Black,
or ite	Fun	1 Yes 2 No			Specify: Whi	+0
irs afte iiral",	ρ	or Dates:	Yes 2X No specify: ent's Usual Occupation (Give kind of	f work done	16b. Kind of Business	
72 hou al Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use re	etired)		
5-0036 led within 72 Hygiene. other than '	du		maker	= 111 ·	Her Home	9
	Be Co	17. Father's Name (First, Middle, Last)	18.Mother's Nan Simon:	ne (First, Middle, Manne) ne Mor		
2121 uld be fi Mental marked c event,	To B	Emilien Peloquin 19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number of			e, Zip Code)
MD nd 2 sho alth and m 27 is			rtle Dove Ct., G			20879
o			osition (Name of cemetery, other place)		20c. Location - City o	
imo Page ment o tant: or oth			o ^{ther place)} Aug. 23, itan Funeral Ser			a, Virginia
Baltimore, permit. Pages I ar Department of He Important: If ite injury or other tr		21. Signature of Funeral Service Ucensee M00668	Name and Address of Facility illiams Funeral	Home, P.A	١.	0.0510
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter	270 Hawthorne Rd the mode of dying, such as cardiac	or respiratory arre	N Head Mid st, shock, or heart	20640 Approximate Interval
/Medical		failure. Litterly one cause on each line. Immediate Cause (Final disease a. Atherosclerotic cardiova	ascular disease			Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):				
	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		ŧ		
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events requiring in death), last Due to (or as a consequence of):				
ecuted and - transit		events resulting in death) Last Due to (or as a consequence or): d.				
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Box 68° e death certifi the attending ed for use as	/sician/	past 12 months?	Fetal death 3Ectopic preg Other (Specify)	nancy	Month	Day Year
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i, P.O. ires that the signed by	by P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		2 No 3 Pro	bably 4 V Unknown
ds, l				24a. Was a		utopsy findings available
cords, law requir has been s	Completed			_ autops perform	ned? death?	
Vital Rec ysician: The l his certificate l director, page	S	25. Was case referred to medical	26.Place of Death (Chec	1 Yes 2	No 1 🗸	res 2 No
Vita ysicia his cer direct	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	nt 3 DOA Other: Nur	sing Home 5 F	Residence 6 🗸 Oth	er: Scene
of of ing Ph	n: T	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 1X Natural		28d. Describe h	ow injury occurred	
IVISIOR or Attend after death Director:	catic	2 Accident Investigation 28e. Place of Injury - At home, farm, sti	1 Yes 2 No	29f Loanting (C	troot and Number or E	Rural Route Number, City
Division of Vital Records, P.O. pital or Attending Physician: The law requires that to ours after death. First Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detected.	Certification	3 Suicide 6 Could not be determined (Specify)	eet, factory, office building, etc.	or Town, St		tural Route Number, Only
Hospit 24 hour Funer tely fil		29a. Certifier Check only 1 Certifying Physician: To the best of my knowledge, death occ				
Division of Vital Records, P.O. Box 68760, To the Itospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner:On the basis of examination and/or investige and manner stated.		d at the time, date a		
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (M August 17, 200	
		ANI COMPANY	J.J.IVI.L.		7.ugust 17, 200	
JB.		30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Pe	enn Street, Baltimore, MD	21201		
	tate	31. Date filed (Month, Day Year) 4 2007 32. Figure 3. Signature	parte			
Regi	417617	HUU A T LOUI MAGNOT NO POR				

07-06139

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

NK UNK	1- For State of Maryland / Department of Health and Merital Certificate of Death	
Physician/	1. Decedent's Name (First, Middle,Last)	Reg. No. 2. Date of Death Month Day Year August 9, 2007 3. Time of Death 2310 hrs
ledical Examiner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of D Landover	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2	
Maryland 28a-f show any d at once. ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location New Carroll to 10e. Street and Number 10f. Zip Code	10d. Inside City Limits 1 X Yes 2 No 10g. Citizen of What Country?
s after death with the Iran", or items 23a or inner must be notified by Funeral Dit	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? 14. Was Decedent of Hispanic Origin? 15. Never Married 16. Decedent of Hispanic Origin? 17. Yes 18. Was Decedent of Hispanic Origin? 18. Was Decedent of Hispanic Origin? 18. Was Decedent of Hispanic Origin? 18. Was Decedent of Hispanic Origin? 18. Yes, specify Cuban, Mexican, Pt. 19. Yes 2 No specify: 19. Yes	(Specify Yes or No- perto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black
15-0036 Jied within 72 hours at Hygiene. If other than "matural to the Medical Examing the Medical Examing Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use	e retired) Tra Electrical
D 21215-0036 should, be filed within 7 and Mental Hygiene. 7 is marked other timan natic event, the Medical To Be Compli	Mohamed Jakoul Rku 19a. Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number)	Name (First, Middle, Maiden Sumame) Ondr Wkite Jakoub Tor Rural Route Number, City or Town, State, Zip Code)
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event, To Be	20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place) 22c. Name and Address o actity	Date 20c. Location - City or Town, State Alelphi M After M. M. m. I-M Date 20c. Location - City or Town, State M After M. M. m. I-M
Physician 'Medical caminer	23a. Part I Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardifailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	liac r respirator arrest, shock, or heart Approximate Interval Between Onset and Death
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60, ate be executly sician and by sician and burial - tri	UNPENDED AMENDED	23d. Date of delivery
Box 68760, e death certificate be execu the attending physician and ed for use as the burial - tra hvs.ician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic p 9 Unknown	regnancy Month Day Year
P.O. Bc s that the des gned by the a detached fo		I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physiciau: The law requires that the death certificate be executed him 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and nightedy filled in by the funeral director, page 2 should be detached for use as the burial - transfical Certification: To Be Completed by Physician/Medical E		24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 No No No No No No No No No No No No No N
f Vital Physiciau: or this certifical director	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other; Other; Other; Other; Other; Other; Other; Other; Other; Other; Other; Other; Other; Other; Other; Other;	Nursing Home 5 Residence 6 🗸 Other: Scene
on of anding Ph. Ith.	27. Manner of Death 28a. Date of Injury (Month, Day Year) Aug 9, 2007 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 V	28d. Describe how injury occurred Subject assaulted
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	2 Accident Investigation 3 Sulcide 6 Could not be determined (Specify) Cemetery	28f. Location (Street and Number or Rural Route Number, City or Town, State) 7101 Sheriff Road, Landover, Md.
To the Hos within 24 h To the Fun completely		e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)
of cor	and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) August 10, 2007
	30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, M	D 21201
Stat	DOS Deviatores Significan	

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

OGME

1-1. De

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician /Medical

Examiner

Funeral

Director

efmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show mi righty or other traumatic event, the Medical Examiner must be notified at onze.

Physician /Medical Examiner

	Please T						. Ensure		-		gible.	
For State Registrar		State of	t Maryla			nent of I icate of	Health and Death	Mer		ene . No. 2 (007	27820
1. Decedent's Name	(First, Middle, Last) Kosiorek	Augus	ıt.						Date of Death Month	Day	Year	3. Time of Death
4a. Facility Name (If r.					4h	. City. Town	or Location of Dea		gust	26 4c. Cou	2007 nty of Death	11:10p M
	Maris Hos					wson					imore	
5. Social Security Nur 214–14–85		M 217F	7. Age (In y	rs. last birthd	Mo	Under 1 Year onths Days	If Under 24 Hrs Hours Min		Date of Birth (Month, Day, Y	ear) .921	Cou	place (State or Foreign intry)
Usual Residence of D	Decedent 10b. County		100	City, Town or	r Locatio	n						10d. Inside City Limits
MD	Carroll		100.	Sykes								1 □Yes 2 XNo
10e. Street and Numb	ber				1	Of. Zip Code			100	j. Citizen	of What Cou	intry?
4782 Arli	ngton Dri	ve				2178	34		Ţ	JSA		
11. Marital Status 1	d 2 Married	2. Was Dece Armed Fo 1 ☐ Yes If Yes, Giv	rces? 2.∏-No	1 U.S. 1	_	Decedent of I s, specify Cub Yes 2127 No	Hispanic Origin? (Span, Mexican, Puer Specify:	Specify rto Rica	Yes or No- an, etc.)	E	Race - Ameri Black, White	, etc.
3 XWidowed 4		Year or Da	ates:								cify: whi	
(Specify	15. Decedent's Educ iy only highest grade	completed)		16a. De	ecedent' live kind fe. DO N	s Usual Occu of work done NOT use retire	pation during most of wo d)	orking	1		f Business/la	
Elementary/Second	dary (0-12)	College (1	-4or 5+)		spec		-,		1	Vesti	.nghou	se Corp.
17. Father's Name (F Stanis1	First, Middle, Last) aw Bogos1	awski		•	_		18. Mother's Na Vincent				,	
19a. Informant's Nam Leo Kosio							and Number or F					ip Code)
	Cremation 3 □Re	emoval from	State		cremato	ry or other pla	ery 8-30	Date	-		on - City or T	
4∐Donation 5	o ☐ Other (Specify) eral Service License	e.		Oly KO	-		ess of Facility Ha		I .		•	
/ . ``	Haight &		ut				95 Sykes					опарет
23a. Part1. Enter the shock, or heart	e disease, or complic failure. List only on	ations that c	aused the de								1	Approximate Interval Between
Immediate Cause (Fi				ASCULAR ACCIDENT						Onset and Death		
resulting in death)				sequence of):								
Sequentially list cond	ditions, b.	Due to (Due to (or as a consequence of):									
Sequentially list condition if any, leading to immoduse. Enter University Cause or in that is it lated a section.	ying njury	Due to (or as a consequence of):										
that initiated events resulting in death) La	C.	C Due to (or as a consequence of):										
	d.											
IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ yes 2 🔀 9 □ Unknown	nonths?		inth 2 ☐ F ant at time o	etal death		opic pregnanc ner (specify) _	ÿy				Date of delive	very Day Year
Part II. Other signific	cant conditions con	tributina to de	eath but not i	resulting in th	e under	lvina cause ai	ven in Part I.		23e. Did toba	cco use c	ontribute to	the cause of death?
										2 □ N		
									24a. Was an autopsy performe		tb. Were aut prior to c death? 1 □ Yes	topsy findings available ompletion of cause of
25. Was case referre examiner?	ed to medical						26. Place of De	ath (C		Be 140	,	
1 ☐ Yes 2 X N	lo H		·	ER/Outpa		D DOX		Home	5 Residen	ce 6 X	Other (Spec	ify) HOSPICE
27. Manner of Death 1 X Natural 2 ☐ Accident	5 Pending investigation	28a. Date ((Mont	of Injury th, Day Year	28b. Tim Inju	ry	28c. Inju Wo M 1	iryat irk?]Yes 2 ∐ No	28d	. Describe how	injury oc	curred	
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place buildi	of injury - A ng, etc. (Spe	t home, farm,	, street,	factory, office		28f.	Location (Stre City or Town,		ımber or Ru	ral Route Number,

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, <

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Part 25. \ 27. N 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DR. TARIQ MAHMOOD

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

			1- State of Maryland / [Registrar	Department of Health Certificate of Death	and Mental H		27821			
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of D	neg. No.	3. Time of Death			
	Physicia /Medic		Anthony Houston		Month	Z bay Year	18:42 M			
}	Examin		4a. Facility Name (If not institution, give street and number)	4b. Gity, Town, or Location		4c. County of Deat				
	3 10 10		Northwest togs, In Conten		er 24 Hrs. 8. Date of E	15017	mag			
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bit	Yrs. Months Days Hours		Day, Year) Co	nplace (State or Foreign untry) yland			
Ī	pud M		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	n or Location		11/	10d. Inside City Limits			
	Maryla f sho	lor		terstown			1 □ Yes 2√□ No			
	r 28a-	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	untry?			
	th with	al D	217 Church Road	21136		USA				
	tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic	Origin? (Specify Yes or f can, Puerto Rican, etc.)	No- 14. Race - Ame Black, White				
35	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or Items 23a or 28a-f show event, the Medi-al Examiner must be notified at	by F	1 □ Never Married 2 ሺ Mamed 1 ሺ Yes 2 □ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates: ¶ 45 – 47	1 ☐ Yes 2 ☒ No Specif	Specify: wh	ite				
9500-61212	72 hou	ted		Decedent's Usual Occupation	act of warking	16b. Kind of Business/Industry				
12	ithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during mo life. DO NOT use retired)	ost of working					
	iled w Hygiel Iher tl nt, th	Ö	10 0	sales manager	ther's Name (First, Midd	life insu	rance			
/land	d d d d d d	To Be	Anthony Aquilano		rrie Rizzo					
E.	2 should be and Ments Is marked aumatic er	-	19a. Informant's Name/Relationship (Type. Print) 19th	nber or Rural Route Nun	nber, City or Town, State, 2	Zip Code)				
	es 1 and 2 of Health a f Item 27 Is r other trai			17 Church Road F	Reisterstow	n, MD 21136				
saitimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 Is marke any Injury or other traumatic ance.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremeţion 3 ☐ Removal from State 20b. Place o cemete	f Disposition (Name of ry, crematory or other place)	Date	20c. Location - City or	Town, State			
	permit. Page Department of Important: If any Injury or once,		4 Donation 5 Other (Specify)	22. Name and Address of Fac	cility					
ğ	Depar Impo any Ir		21. Signature of two Service Licensee Wade Virector	Baltimore, MD	Board 655 W 21201		Street			
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such a	as cardiac or respiratory	arrest,	Approximate Interval Between			
)	Physician		Immediate Cause (Final disease or condition resulting in death)		1000 Syno	nont	Onset and Death			
	/Medical Examiner		Due to (or as a consequence	esst Flinc	Auto Da					
120		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		1 policing 1	vec ys				
	ecutec tnd transi	Examiner		ratory DISTRO	95 Sync	izome				
8/60,	the death certificate be executed y the attending physician and iched for use as the buriat-transit	al E	resulting in death) Last ue to (or as a consequence	H Failure						
200	fficate p phys	edical	d. Hewle Ediv	4) MAJJURE						
X R R	w requires that the death certific been signed by the attending I should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	n 3 ⊟Ectopic pregnancy		23d. Date of de	•			
о С	e dea the att	sicis	in the past 12 months? 1	5 Other (specify)		Month	Month Day Year			
J.	that the ed by detacl	Phy	Part II. Other significant conditions contributing to death but not resulting i	n the underlying cause given in Par	rt I. 23e. Di	d tobacco use contribute to the cause of death?				
Hecords,	requires that een signed b hould be deta	d by			1]	1 Yes 2 No 3 Probably 4 Unknown				
O O	law rei	Completed			24a. W		topsy findings available			
	The law ate has be	Com			pe 1□ Yes	rformed? death?	completion of cause of 2 □ No			
VItal	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: Ho	Other	ace of Death (Check onl	y one)				
ö		2:	27. Manner of Death 28a. Date of Injury 28b.	apatient 3 DOA 4 1		esidence 6 Other (Spe	cify)			
0 0	Attending r death. ector: After by the funer	ation		Time of lnjury at lnjury Mork? M 1 Yes 2[o non mjury dodanica				
DIVISION	r Attenditer death.	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, for building, etc. (Specify)	arm, street, factory, office	28f. Location City or 1	(Street and Number or Ri Fown, State)	ıral Route Number,			
	spital or Attending Physiours after death. Increal Director: After this filled in by the funeral di		29a. Certifier Certifying Physician: To the best of my knowledg	a dooth approved at the time date						
	Fur 4 h	Medical	(Check only one) Medical Examiner: On the basis of examination at and manner stated.	nd/or investigation, in my opinion, d	death occurred at the tim	ne cause(s) and manner as ne, date and place, and du	e to the cause(s)			
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mont				
)				Do H3607	8	8-27-2	007			
			30. Name and address f person the completed cause of death (Item 23a)	(Type, Print) + Nond Randa	11.1 1	2113	2 2			
	Sta	ite	31. Date filed (Month, Day, Year) 32 Registrar's Signature	1 WAG ICANDA	ין אטיפונוי	()				
	Registr	ar	AUG 3 0 2007 James Ja	Agarles .						
-		004		ALC: A COLUMN TO THE PARTY OF T						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 23 2007 Aug. 9:15am M ALICE **BROOKS** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Heartland of Hyattsville Hyattsville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Social Security Number 6. Sex **Funeral** Months 1 □ M 2 🔀 F 1934 Washington, DC 6, 577-48-3315 72 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Hyattsville MD Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with USA 20785 1908 Palmer Park Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian 11 Marital Status Black. White, etc. a filed within 72 hours after dan Hygiene.

Other than "natural", or Item 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify. Specify: ≥q 3 ☑ Widowed 4 ☐ Divorced Black Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Housewife None 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louise Miller David Johnson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hyattsville, MD. 20785 1908 Palmer Park Rd. Darlene Smith/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 3 Removal from State 1 Burial 2 Cremation 8-30-2007 Landover, MD. 4 □ Donation 5 □ Other (Specify) Harmony Memorial 22 Name and Address of Facility Marshall's Funeral Home, Inc. 21. Signature of Funeral DC 20011 4217 9th St. N.W. Washington, Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical REFARCTION Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending ph for use as t 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1☐ Yes 2 2 No 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate has b irector, page 2 sl autopsy performed? 2 1 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4⊠ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After Injury 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Algust 29 2007 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 7325A HAMOVER

-32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 4:05 a M 24 2007 Barnard August Billings Dowe 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death N/A Joseph Richey Hospice Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday APR 30 1926 Days Hours 1⊠M 2□F 81 Texas 455-22-8496 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 USA 1002 Spring Gate Road, Unit 2A Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 SYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 K No Specify: Specify: White Completed by 3 Widowed 4 Divorced WWII 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Federal Reserve College (1-4or 5+) Elementary/Secondary (0-12) Bank Editor/Economist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernie D Lorabelle Billings Barnard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21228 19a, Informant's Name/Relationship (Type, Print) Billie Roche Barnard - wife 1002 Spring Gate, Road, Unit 2A, Catonsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 8/28/2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Sicensee H Cremation Society of Maryland, 299 Frederick Road, Baltimore, Williams u ノレ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Renz Due to (or as a consequence of): Physician/Medical Plerium IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1☐ Yes 25. Was case referred to medical 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 🗀 Y 6 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

O. Barnago Division or Vital Records,

attending physician and for use as the burial-transit signed by the a peen page 2 s has certificate after death.

Director: After this completely filled in by the funeral 0 To the Hospital of within 24 hours at To the Funeral D

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event the MADILL IT.

Physician

/Medical Examiner

Baltimore, Maryland 21215-0036

State Registrar

Medical

31. Date filed (Month, Day, Year) AUG 3 0

pre and title of certifie

29a. Certifier

29b. Signa

(Check only one)

29c. License number

1 vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Bel+mon MO 2/210-1303

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

2007

Wi hele Ave 32 Registrar's Signature

farte

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3150 ARI **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Social Security Number Days **Funeral** 1□M 20 Hours Min Months 82 JUL 11 1925 California 217-56-3723 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland ia or 28a-f show t be notified at 10a. State 1 ☐ Yes 2X No Director MD Anne Arundel Severna Park 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21146 "natural", or items 23a edical Examiner must b 43 W. MacKenzie Road, Apt. 306 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ⅓No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify: White Completed by 3 Nidowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the 5+ Library <u>Librarian</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Ingham Gertrude Pau1 С. Sischo 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health an Important: If item 27 is 13704 Beauwick Court, Silver Spring, MD 20906 Byron Betts - son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 8/30/2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liganseven H. Williams ²² Name and Address of Facility Cremation Society of Maryland, 299 Frederick Road, Baltimore, 21228 Wi 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Peath Immediate Cause (Final disease or condition resulting in death) *w*c **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 Live birth Month Year in the past 12 months? Day for 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b director, page 2 s autopsy performed? Yes 2000 2∏No parie 1 ☐ Yes To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Depatient 2 ER/Outpatient 3 DOA 1 🗌 Yes Medical Certification: To Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural
2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Daye signed (Month, Day, Year) 29c. License number 29h Signature and title of certifier no completed cause of death (Item 23a) (Type/Print) 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 3 2007 -0

Registrar
DHMH 17 Rev 1/2001

State

Year)

32 Registrar's Signature

		-	State Registrar	State of Maryla		rtificate of L	Death	Reg. I	¹ ^e 2007	27826
	Physici	an	1. Decedent's Name (First, Middle, Lest) Anna K. Blankensh	ip				Date of Death Month GU9 &	Day Year 8 2007	3. Time of Death
	/Medic Examin	er	4a. Facility Name (If not institution, give str STAGNES 5. Social Security Number 6. Sex	eet and number)	rs. last birthday) Yrs.	4b. City, Town, or 3 9 / 7 (If Under 1 Year Months Days	Location of Death		4c. County of Death	
	Director -f show ified at	ctor	Usual Residence of Decedent 10a. State	10c.	City, Town or Lo	cetion Arbu			1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the	I Direc	10e. Street and Number 5535 Link Avenue			10f. Zip Code	227	10g.	Citizen of What Coun United St	
0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	d by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	R. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	ispanic Origin? (Speci in, Mexican, Puerto Ri Specify:		14. Race - Americ Black, White, Specify:	^{etc.} White
21215-0036	ithin 72 h ne. nan "natu e Medica	Completed	15. Decedent's Education (Specify only highest grade and Elementary/Secondary (0-12)	College (1-4or 5+)	(Give		ation during most of working I)	1 100		,
		Be Cor	17. Father's Name (First, Middle, Last)		[Iomemaker	18. Mother's Name (ŕ	ome
arv <u>la</u>	should b and Ment marked	2	Charles Benet 19a. Informant's Name/Relationship (Type				and Number or Rural		ty or Town, State, Zip	Code)
ė Š	P = L =		Charles Blankensh				Avenue, A		MD 21227 Location - City or To	own, State
Baltimore, Maryland	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other		United the second seco	A A	Ceme	osition (Name of matory or other place of ark of ark of ark of a supplementation of the supplementation of a suppl	8-31-2 ss of Facility Amba nur Spring	cose Fune	Baltimore, eral Home, outus, MD	Inc.
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the decause on each line. Due to (or as a con	mal	ter the mode of dyin	g, such as cardiac or	respiratory arrest,	teak	Approximate Interval Between Onset and Death
NNA S.	icate be executed physician and sthe burial-transil	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con-						
A/8260.	icate be physicial the buri	dical	C d.							
hip O. Box	ath certif attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ ₩o 9 □ Unknown	c. If yes, outcome pf pre 1 Live birth 2 If 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	У		23d. Date of deliv Month	ery Day Year
eNS rds P	w requires that the de been signed by the s	by	Part II. Other significant conditions conf	ributing to death but not	resulting in the	underlying cause giv	en in Part I.	23e. Did tobac	co use contribute to t	the cause of death?
19 N Ken		Completed						24a. Was an autopsy performed 1 Yes 2	death?	opsy findings available impletion of cause of
m>	ysician: Th is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient	2 ☐ ER/Outpatie	ent 3 DOA Oth	26. Place of Death her: 4 ☐ Nursing Hom		e 6 □Other (Speci	ify)
on or	Jing Ph J. After th funeral		27. Man of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time Injury	Wor	ryat 2 rk? Yes 2 □ No	8d. Describe how	injury occurred	
Division	i giệc	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - A building, etc. (Sp	At home, farm, s pecify)	treet, factory, office	25	Bf. Location (Stree City or Town, S	t and Number or Rur State)	al Route Number,
	Hospital 24 hours a Funeral etely filled	Medical C	29a. Certifier 1 Certifying Phys (Check only one)	Ician: To the best of my ler: On the basis of examend manner stated.	knowledge, dea mination and/or i	th occurred at the ti nvestigation, in my	me, date and place, a opinion, death occurre	nd due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	ipinen	î Y.D	29c. Licens	se number _ 6 3 0 7	29d.	Date signed (Month)	, Day, Year)
	4		30. Name and address of person who could be a second of the second of th	1 (S) 1 2 Registrar's S	02 W	·Maple	Rd Li	uthic	um, Ml	21090
	Regis	ate trar	AUG 3 0 200	19.	S. A	and				

State Registrar DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	aryland	-	artment of h		d Mental Hy		007	278	127						
n gr	Physici	_	1. Decedent's Name (First, Middle, Las KEVIN RALPH I						2. Date of De Month AUGUS	eath Day		3. Time 1:1	of Death						
	/Medic Examir		4a. Facility Name (If not institution, give National Institut	,	. L		4b. City, Town, o			4c.	County of Death	1							
Ü	Funeral Director		5. Social Security Number 6. S 6. S 6. S 6. S 6. S 6. S 6. S 6.		e (In yrs. las	st birthday) Yrs.	Bethesd If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bin (Month, Date Jan 2,	th ay, <i>Year)</i>	Cqu	ry nplace (State intry) iforn	or Foreign ia						
	hours after death with the Maryland tural", or liems 23a or 28a-f show al Examiner must be notified at	lor	Usual Residence of Decedent 10a. State 10b. County CA Santa C1	ara	10c. City, 1	Town or Lo	cation					10d. Inside	City Limits						
		Funeral Director	10e. Street and Number 6179 De Palma Ct.				10f. Zip Code 95120				zen of What Co	untry?							
920	n 72 hours after deatl "natural", or Items 2 edical Examiner mus	þ	11. Marital Status 1 \(\frac{N}{2} \) Never Married 2 \(\triangle \) Married 3 \(\triangle \) Widowed 4 \(\triangle \) Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:				lispanic Origin an, Mexican, F Specify:	? (Specify Yes or No Puerto Rican, etc.)	U.S.	14. Race - Amer Black, White								
21215-0036	within 72 ho ene. than "natur. he Medical I	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5	+)	16a. Deced (Give life. L	lent's Usual Occup kind of work done OO NOT use retire	nation during most of d)	working		nd of Business/I	•							
nd 21	be filed withir tal Hygiene. d other than event, the Me	Be	11 17. Father's Name (First, Middle, Last)			Stude	ii L	18. Mother's	Name (First, Middle		h Schoo	<u></u>							
Maryland	2 should be and Mental is marked o raumatic ever	2	John Ralph Bertsc 19a. Informant's Name/Relationship				-	and Number o	a M. Richt or Rural Route Numb	er, City o		ip Code)							
nore, N	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical Once.		John R. Bertschy / 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi		20b. Plac	ce of Disponetery, cren	sition (Name of natory or other pla	ce)	n Jose, C	20c. Lo	cation - City or								
Baltimore,			21. Signature of Funeral Service Licer		Ches	. 22	e Cremato Name and Addre app Fune	ss of Facility	/28/2007	022	tsville Gist A es:Silv		20910 _{MD}						
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lin	ple i	Do not ente	er the mode of dying the failu	ng, such as ca	rdiac or respiratory a	rrest,		Approxim Interval E Onset an	iate letween						
,092	te be executed ysician and ne burial-transit	Physician/Medical Examiner	ical	ical					Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a consequer へんのか a consequer	na						yeo	US
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Il Records,	The law recate has be page 2 sho	Completed by				0			24a. Was auto perfo 1 Ves		24b. Were au prior to death? 1 ☐ Yes	ompletion of	s available cause of						
Vita	Physician: this certific	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Minpatie	nt 2∏ER	NOutpatien	t 3□ DOA Oth	or:	Death (Check only only only only only only only only		S □Other (Spec	ify)							
Division or Vital	To the Hospital or Attending Physician: The law within 24 Hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day		8b. Time of Injury	28c. Injur Wor M 1	v at	28d. Describe			,,							
Divis	ital or Atturs after de ral Directurel bir by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, etc	:. (Specify)				City or To	wn, State			ımber,						
	To the Hospital within 24 hours a To the Funeral a completely filled	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best on iner: On the basis of and manner sta	examination	edge, death n and/or inv	occurred at the tile restigation, in my o	me, date and popinion, death	place, and due to the occurred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause	e(s)						
	Tot Tot Com	Σ	29b. Signature and title of certifier	(Daris	en	M.Z		e number	712_	29d. Date	e signed (Month $27/20$	Day, Year,							
	H		30. Name and address of person who o	completed cause of de				VE. BF	ETHESDA.	MD	20892								

State Registrar 31. Date filed (Month, Day, Year)

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10 CENTER DRIVE, BETHESDA, MD

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State of Maryland / Department of Health and Mental Hygien 2007	

hysici: /Medic	an	Registrar 1. Decedent's Name (First, Middle, Marie E.	Last) Bent			rtificate of			2. Date of Deat Month August	Day	Year 07	3. Time of Death
xamin		4a. Facility Name (If not institution,		or)		4b. City, Town, o	or Location			1	y of Death	
		Broadmead	-			Cocke	-			_1	altim	
neral ector		5. Social Security Number 168-32-8627	6. Sex 7. / 1 ☐ M 2 ▼ F	Age (In yrs. last b 91	birthday) Yrs.	Months Days	If Under Hours	Min.	B. Date of Birth (Month, Day, July 6,	Year)	9. Birthp Cour	plece (State or Fore
		Usual Residence of Decedent		71					JULY 0	1910	Cub	<u>a</u>
1 at		10a. State 10b. County		10c. City, To	own or Lo	ocation					1	Od. Inside City Lin
or other treumatic event, the Medical Examinat must be notified at	Director	Maryland Balt	imore	C	ocke	ysville						1 □ Yes 2 🛣
a s		10e. Street and Number				10f. Zip Code			10	0g. Citizen of	What Cour	ntry?
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vent, the Ma	e Co	12 17. Father's Name (First, Middle, L	ast) 03		Tut	erior De			First, Middle, N	Resid		<u> </u>
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umatic ev		19a. Informant's Name/Relationsh			9b. Mailir	ng Address (Street						Code)
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othe		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of matory or other place		Da		20c. Location		
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DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene Amend Items 24a,25,26,27,29a per dr. 28/0.08/30/0/drb Reg. No. 2 0 0 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Dorothy Engelhardt Butts AUGUST 2007 06:05PM 21, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 22, 1926 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√□ F 80 Director 213-20-9439 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at 1 ☐ Yes 🍇 ☐ No Maryland Baltimore Timonium Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Item 27 Is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a 12011 Tralee Road 21093 LISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed by 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) Insurance Agent Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fill of Health and Mental Health and Mental Health are reserved or the state of the stat Be Robert Schwartz Marie Grieb 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan M. Engelhardt/Daughter 1 Bramleigh Road Lutherville.Md. 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 □Cremation 3 □Removal from State 4 □Donation → Other (Specific o = Injury or Important: Moreland Mem.Park Cem. 8/24/07 Baltimore, Maryland 21. Signature of Functor 22. Name and Address of Facility 1050 York Road a Ruck Towson Funeral Home, Inc. Towson, Md. 21204 On 23a. Part1. Enter the disease or composations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Immediate Cause (Final **Physician** MULTI SYSTEM ORGAN FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CARDIOPULMONARY ARREST if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner signed by the attending physician and detached for use as the burial-transit INTRAPELVIC AND INTRAABDOMINAL HEMATOMA Due to (or as a consequence of) P.O. Box 68760, COAGULOPATHY IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by ANOXIC ENCEPHALOPATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown COMPLICATIONS OF ATRIAL FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has performed? 1□ Yes No Division or Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2X No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 2 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D24034 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON, MARYLAND 21204 TIMOTHY LOW. M. D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 3 0 2007

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			For State of Maryland / Department / Department / Department / Department / Department / Department / Department / Depart	artment of Health and M rtificate of Death		ene g. No 2007	27830
1.	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Robert Berkheimer 4a. Facility Name (If not institution, give street and number)	4b, City, Town, or Location of Death	August	22 200 4c. County of Death	78:05 PM
10	Examili	ier k	Doctor's Hospital	Lanham		Prince Geo	orge's
S.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 √√ M 2 □ F 7. Tyrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birthp	place (State or Foreign ntry) unk
	Director		Usual Residence of Decedent		Jan 1, 1	942	
	arylan show ed at	'n	10a. State 10b. County 10c. City, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	Director	MD Prince George's Landove 10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	
	th with 23a or ist be	a Di	6601 Seattle Land	20784		USA	
Naryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at		by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2🌠 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: whi	etc.
15-00	in 72 hou n "natura ledical E	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of workl DO NOT use retired)	unk 1	6b. Kind of Business/In	dustry unit
212	ed with giene. er thar , the N	Comp	Elementary/Secondary (0-12) College (1-4or 5+) unk unk	,			
and	I be file ntal H) ed oth	Be	17. Father's Name (First, Middle, Last)	unk 18. Mother's Name	(First, Middle, M	laiden Surname)	unk
ary	should and Me mark mark	٦ ک	19a. Informant's Name/Relationship (<i>Type. Print</i>) 19b. Mailir	ng Address (Street and Number or Rura	al Route Number,	City or Town, State, Zip	Code)
Ž,	and 2 ealth a m 27 is		Doctor's Hospital 818	Gook Luck Road La			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic en		4 Donation 5 Openity) in state	natory or other place)		20c. Location - City or To	
Bal	permit. Departr Imports any Inji		110111111111111111111111111111111111111	eltimore, MD 2120		Baltimore S	Street
	Physician		23a. P. 11. Enter the dise se, or complications that caused the death. Do not ent shick, or heart failure. List only one cause in each line. Immediat. Cause (Final disease or condition	er the mode of dying, such as cardiac of	or respiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to car as a consequence of	s follows			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury test britised	ny Januic			
	cate be executed oblysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):				
8760,	e be ex rsician e buria	dical E	d d				
Õ	ertificat ng phy e as the	Medi	IF FEMALE:				
O. Box	the death certific / the attending p ched for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pt pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
rds, P	w requires that the d been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did toba	acco use contribute to ti s 2 □ No 3 □ Prot	he cause of death?
al Records,	The larate has	Completed			24a. Was an autopsy perform	prior to co	opsy findings available mpletion of cause of
Vital	Physiclan: Th this certificate raf director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 → Hospital: 1 ★Inpatient 2 ☐ ER/Outpatien	26. Place of Death		·	
ם ר	ding Phys n. After this funerat dir	\vdash	27. Manner of Death 28a. Date of Injury 28b. Time of		ne 5 □ Resider 28d. Describe hov	nce 6 Other (Special w injury occurred	y)
<u> </u>	tendir leath. tor: Af the fur	catio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
DIVISION	afor At after of Direct d in by	Certification:	3 Suicide determined determined 28e. Place of injury - At home, farm, structure building, etc. (Specify)	eet, factory, office	28f. Location (Str City or Town,	eet and Number or Rura State)	al Route Number,
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	ledical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death and manner stated.	n occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the ca ed at the time, da	use(s) and manner as s ite and place, and due t	tated. o the cause(s)
	To the within Comp.	Me	29b. Signature and title of certifier	29c. License number D52500	29	d. Date signed (Month)	Day, Year)
			30. Name and ordress of person who completed cause of death (Item 23a) (Type, Fozia Abdulwahabe, 8118600		cuhan		20706
	Sta Registr		31. Date filed (Month, Day, Year) AUG 3 0 2007 32 Registrar's Signature	wells			

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9. No 2007	2783
	3. Time of Death

6:20

Birthplace (State or Foreign Country)

MD

WHITE

10d Inside City Limits 1 ☐ Yes 2 ☑ No

Approximate Interval Between Onset and Death

YRS

Vear

2.0

Dav

Рм

State of Maryland / Department of Health and Mental Hygiene 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician AUGÜST** ROSE BURMAN 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SLADE AVENUE APT. #213 BALTIMORE BALTIMORE 8. Date of Birth (Month, Day, Year) 03/19/1914 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 1□M 2ŪF 215-10-3026 93 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~-: any injury or other traumatic event. 10c. City, Town or Location 10a, State 10b. County Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 SLADE AVENUE APT. #213 21208 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify. <u>ک</u> 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 10 College (1-4or 5+) HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KAPLAN MORRIS HINDA KRAKAPOLSKI ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3801 CANTERBURY ROAD UNIT #501 BALTIMORE, MD 21218 LAWRENCE BURMAN / SON 20b. Place of Disposition (Name of BETH SAAC ADATH 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 □ Cremation 3 □ Removal from State 08/29/2007 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service deensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final GRONARY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes Completed 24a. Was an was ... autopsy performed? Yes 2,2000 has t□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No 3□ DOA P 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of Certification: Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

23e. Did tobacco use contribute to the cause of death? 212No 3 Probably 4 Unknown

Month

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

5 Residence 6 □Other (Specify)

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

on who completed cause of death (Item 23a) (Type, Print) Name and address of pe

D

Begistrar's Signature

2700 QUARRY LAKE DR, STE 220 BALTITURE

State Registrar

Medical

3 ☐ Suicide

29a. Certifier

29b. Signature

DORES

31. Date filed (Month, Day, Year)

4 Homicide

(Check only one)

6 ☐ Could not be

title of certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

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Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director. filled in by the

			For State Registrar	State of Marylar	nd / Department of H	ealth and Mei Death	ntal Hygien	•	27832
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last) Aa. Facility Name (If not institution, give s	Ethel D	OVIS CAVAI	naughA	Date of Death Month Day		3. Time of Death 4-: 52 A M
	Funeral Director	per ch	214-20-0404	M 28 F 7. Ago (In yrs.	last birthday) If Under 1 Year Months Days 82 Yrs.	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Year) 8/26/24	Coun	lace (State or Foreign try) yland
	e Maryland la-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD n/a	10c. Ci	ty, Town or Location Baltimore				0d. Inside City Limils 1 🎢 es 2 ☐ No
	a or 28	i Director	10e. Street and Number 3320 Benson Ave.		10f. Zip Code 2122	9	10g. Cit	izen of What Cour USA	try?
yland 21215-0036 Suld be filed within 72 hours after death with the Maryland Manual Hygiene. ### And other then "naturel", or Items 23a or 28a-f show	should be filed within 72 hours after death with the Marylan nd Mental Hygjene marked other then "naturel", or Items 23a or 23a-f show maitc event, the Medical Evantiral must be notified at	by Funerai		2. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	J.S. 13. Was Decedent of Hi		y Yes or No- an, etc.)	14. Race - Americ Black, White,	
	within 72 hou ene. then "nature te Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	16a. Decedent's Usual Occupa (Give kind of work done d life. DO NOT use retired, Sales Pers	furing most of working		ind of Business/Ind	dustry
Maryland 21	should be filed ind Mental Hygid marked other umatic event, I	To Be Co	17. Father's Name (First, Middle, Last) Fred Leon Bowen	U	Dates lets	18. Mother's Name (F	irst, Middle, Maider		
Mar	and and sm		19a. Informant's Name/Relationship (Type Mr. Wayne D. Cavana		19b. Mailing Address (Street a				
	es 1 and 2 of Health fitem 27 I		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re	20b. I	Place of Disposition (Name of cemetery, crematory or other place			ocation - City or To	
altimore,	permit. Pages Department of i Important: If it any injury or o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lidense	Lo	oudon Park Cemet			timore,	
Ba	Depa Impo any ir		Lucie	Car 1	<i>y</i>	ens Ave. B			
S. E.	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	av	Jorexia	g, such as cardiac or re	espiratory arrest,	ì	Approximate Interval Belween Onset and Death MUN
8760,	Examiner	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	abetes Muquence of): urrent Uri	ellitus nany T	rait I	n ferti	Vears
D. Box 6	ath certific attending p for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Sc. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al death 3 □Ectopic pregnancy			23d. Date of delive Month	ery Day Year
rds, P.(w requires that the de been signed by the should be detached	by	Part II. Other significant conditions con	tributing to death but not res	sulting in the underlying cause give	en in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to tl □No 3□Prot	1 4
al Records,	i: The law re- icete has bee c. page 2 sho	Completed	Cognitive i	mpairm	en 1-		24a. Was an autopsy performed? 1 Yes 2 No	death?	psy findings available mpletion of cause of
Vital	ysician: Th is certificete director, pag	To Be	25. Was ca → referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient 2	□ER/Outpatient 3□DOA Othe	26. Place of Death (0	Check only offe) 5 Residence	6 ☐Other (Specif	y)
Division of	To the Hospital or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Certification; 7	27. Manner of Sath 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)		yat 280 (? Yes 2 □ No	d. Describe how inju	ry occurred	
DIX:	ospital or Att hours after d unerel Direct ly filled in by i	Certifi	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, factory, office ify)	28f	f. Location (Street a. City or Town, Stat	nd Number or Rura e)	il Route Number,
	To the Hospital or Attent within 24 hours after death To the Funerel Director; completely filled in by the	edicai (29a. Certifier 12 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kneer: On the basis of examinand manner stated.	owledge, death occurred at the tim ation and/or investigation, in my op	ne, date and place, and pinion, death occurred	d due to the cause(s at the time, date an	s) and manner as s d place, and due to	tated. o the cause(s)
	To the Ho within 24 To the Fu completel	Me	29b. Signature and title of certifier	Milm	29c. License	number	29d. Da	ate signed (Month,	Day, Year)
,	7		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type, Print)	3 3 9 1	Au	gust 23,	,200/
	8		Ming Vi MD 35	20 13-0115 UN / 32-20 distrar's Sign	trenne, Ball	Limore, 1	Marylon	nd 2	[22]
	Sta Regist		31. Date filed (Month, Day, Year) AUG 3 0 20	07 See See See See See See See See See Se	It Anastes		*		7

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shmael Antonio	200		n Black Indelible Ink. Ensure	All Copies Are Leg	ibie.
Similaçi Amomo	-00	per State of Maryla	and / Department of Health and	Mental Hygiene	
	1	For State	Certificate of Death		.No. 2007 2783
		egistrar (First Middle Look)		2. Date of Death	3. Time of Death
Physicia		. Decedent's Name (First, Middle,Last)		Month	Day Year
Medical Examir		Ishmael Coop	ev .	August 23,	2007
	•	a. Facility Name (if not institution, give street and no	umber) 4b. City, Town, or Lo	ocation of Death	4c. County of Death
	н	University of Maryland Medical Center	er Baltimore		NIA
		. Social Security Number 6. Sex	7. Age (In yrs. last birthday) If Under 1 Year	If Under 24Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Birthplace (State or
Funeral			Months Days	Hours Min L 2	Foreign . 4
Director	4	215-35-0494 1 LM 2 =	S Yrs.	100.2	7, 1992 Country) Mary and
		Isual Residence of Decedent			
		0a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits
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te Maryland or 28a-f show any fied at once.	5	Maryland NIH			
laryl sa-	ᇶ్	Oe. Street and Number	10f, Zip Code	10	g. Citizen of What Country?
or 7	Director	434 S. Smallwood	St	U223	USA
th th 23a noti	듩┝		to the First in U.S. 42 Was Date don't of History	ania Origina? / Sagaify Vas or No.	14. Race - American Indian, Black;
h wi	Funeral			anic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.)	White, etc.
deat r ite	5	1 Never Married 2 Married Armed F	2 No		Black
fter I", o		3 Widowed 4 Divorced If Yes, Give Ye	ear 1 Yes 2 No	specify:	Specify:
hours a	화	15. Decedent's Education (Specify only highest gra	ade completed) 16a. Decedent's Usual Occupation	n (Give kind of work done	16b. Kind of Business/Industry
hou Fxa	활		during most of working life. D	OO NOT use retired)	1/1
n 72 me jeal	흥	College (Studen	100	NIA
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ed y gar	Completed	17. Father's Name (First, Middle, Last)	18	8. Mother's Name (First, Middle, M	
21 tal I ked	Be	Daymond Coope		Yvanne Short	(
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Fealth and Meinal Hygene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho for other trainmatte event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street a	and Number or Rural Route Num	per, City or Town, State, Zip Code) 21223
sho and and institute	_	Yvonne Shorts-mot	Len 434 5. Sm	rallywood St. A	Pattinge Maryland
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other transmati	. -		20b. Place of Disposition (Name of ceme	, ,	20c Location - Oty or Town State
rite a. G		20a. Met od of Disposition 1 Burial 2 Cremation 3 Removal	from State crematory or other place)	ola la-	200. Education - Oily of Town, Olate
ages nt of	- 1		Western Star C	em 8/3/107	Catonsville, Maryland
rtan en P	H	4 Donation 5 Other Specify:	22. Name and Address of	of Equility 10	111001 01 21000
Baltimore, permit. Pages I an Department of the Important: If ite		21. Signature of Funeral Service Licensee	22. Name and Address of	ranker tou	resal Home, 1.14. globy
		Jan Func	13512 France	MCK AVC. Bay	timore Maryland
Physician		23a. Part I. Enter the disease, or complications that failure. List only one cause on each line.	caused the death. Do not enter the mode of dying, s	uch as cardiac or respiratory arre	st, shock, or heart Approximate Interval Between Onset and
/Medical	- 1	Complet V	Wound of Torso		Death
xaminer	- 1		a consequence of):		
		Due to (or as	a consequence or).		
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** AUGUSTS 2007 09 55 PM Sheila Douglas Casselberry /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Agnes Hospital Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 9. Birthplace (State or Foreign Country) 1928 Nova Scotia 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 27 F 219-28-5014 79 Director 15, Usual Residence of Decedent a or 28a-f show be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Director Catonsville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 815 Winters Lane Apt 202 21228 U.S.A. items 23a "natural", or items 23a death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. hours after 1 ∏ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: white þ 3 Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 72 permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "n. any injury or other traumatic event, the Media once. Elementary/Secondary (0-12) College (1-4or 5+) 10 Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anderson Unknown Marjorie Craik 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donation 5 Other (Specify) Ambrose Funeral Home, Inc.
1328 Sulphur Spring Rd. Arbutus MD 21227 Signature of Funeral Service License 23a. Part I. Enter the disease, or of mp loations that of used the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): embo lus ours /Medical **Examiner** Sequentially list conditions, if any Lauling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a paneaduence of attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Possible deep venous thrombos 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed fibrillation 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? certificate 2□ No Vital 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA o Date of Injury (Month, Day Year) Medical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

E. REED, MD, 31. Date filed (Month, Day, Year) AUG 3 0

St. AGNES HOSPITAL, 900S. CATON AVE., BALTIMORE, MD 21229 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene 2007 27835 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Helen L. Cook 01:00 PM ALXIVER 2007 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea July 2, 1949 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F 58 212-46-4369 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ms 23a or 28a-f show must be notified at Maryland N/A Baltimore 1y∑Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21211 USA 4231 Hickory Avenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items 11. Marital Status "natural", or Iten 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White þ 3√Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: if item 27 is marked other than "range any hijury or other traumatic event, the Med once. than the M Elementary/Secondary (0-12) College (1-4or 5+) Laundry Mat Attendent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mildred Luise Loundermilk Frank Monroe Friend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 1310 Medfield Avenue Baltimore Maryland 21211 Nicole Fisher/Step Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corp. Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/31/07 Towson Marvland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, INc. 5305 Harford Road Baltimore Maryland ette 4 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5 years Physician Due to (or as a consequence of) /Medical Examiner 5 480urs End Stage Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a nonsequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2□ No 1 ☐ Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AUGUST 28, 2007 AT2438946 Sauthia A. Mathew 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Mathew, M.D. - Union Memorial Hospital, MD

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

AUG

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2007 August 27, 10:35 A M Irene Della Cesaro /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 937 Ships Bell Court Annapolis If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 🗓 F 7, Director 220-16-4339 81 Jan. 1926 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 Yes 2 No Director Annapolis Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21401 USA 936 Ships Bell Court Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 12 of Health and Mental Hygid item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Della Welch Horace M. Adams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 937 Ships Bell Court Annapolis, MD 21401 Peter Cesaro/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of IImportant: If ite
any Injury or ot
once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 8/28/2007 Alexandria, VA 4 Donation 5 Dother (Specify) Crematory 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licenses 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CHE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ESRD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Iniury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

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DHMH 17 Rev 1/2001

State

Registrar

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Year)

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32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D26373

29d. Date signed (Month, Day, Year)

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Baltimore, Maryland 21215-0036

Box 68760. P.0. Division or Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27837 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vea **Physician** 4:09 AM Jacob Caison 2007 August /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examine 5. Social Security Number Unk 6. Sex Baltimore 8. Date of Birth (Month, Day, Year June 14, 1 If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 □ F unk Yrs. 82 Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10d, Inside City Limits 28a-f show a or 28a-f show 1√TYes 2 □ No Director MD Baltimore 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21215 USA 2525 W. Belvedere Avenue 23a traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.SUNK 13. Was Decedent of Hispanic Origin? (Specify Yes or No Armed Forces? 14 Race - American Indian unk or Items Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: black 1 ☐ Yes 2 ☒ No 3 3 Widowed 4 Divorced "natural" Completed unk 16b. Kind of Business/Industry 16a Decedent's Usual Occupation unk 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unk lunk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk Be ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health at
Important: If Item 27 is any Injury or are Sinai Hospital of Baltimore 2401 W. Belvedere Avenue Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state State Anatomy Board 655 W. Baltimore Street Funeral Sev Kon I d 21201 Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediat Cause (Final disease or condition resulting in death) Physician Preumonitis Aspiration /Medical Due to (or as a consequence of) Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): physician pe Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No certificate 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D59062 August 21, 2007 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chad J. Hanson, M.O. 2401 W Belvedere Baltimore MΔ 21215 31. Date filed (Month, Year) 32. Registrar's Signature Day JG State

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 2. Date of Death 1. Decedent's Name (First, Middle, Last) August 26, 2007 Albert L. Donnelly 12:20 A^M 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Manor Care Woodbridge Valley Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 2, 1928 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 1**∑**M 2□F Months Days Hours Maryland 220-18-8300 79 Aug. Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 1 ☐ Yes 2 ☑ No Baltimore Relay 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5731 Mineral Avenue 21227 United States 12. Was Decedent Ever in U.S. Armed Forcee? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore Gas & Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Electric Company 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert Martin Donnelly Florence Loomis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 31781 Kenilworth Dr., Salisbury MD 21804 se of Disposition (Name of Date 20c. Location - City or Town, State Alan Scott Donnelly - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Dopation 5 DOther (Spacify) Loudon Park Cemetery 8-30-2007 Baltimore, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Euneral Service Lidensee 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final METASTATIC CARCINOMA disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nonknown ALC IDENT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Physician /Medical Examiner

be executed

Division or Vital Records, P.O. Box 68760.

Hospital or Attending Physician:

permit. Pages 1
Department of H
Important: If Ite
any injury or ot

Physician

/Medical

Examiner

10a State

Funeral

Director

iral", or items 23a or 28a-f show Examiner must be notified at

natural",

other traumatic event, the Medical

s 1 and 2 should be filed within 'f Health and Mental Hygiene.
Item 27 is marked other than "

Pages 1 and 2 should

72 hours after death with

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

Examiner sician and burial-trans attending physician for use as the buria Physician/Medical been signed by the should be detached \$ Completed has certificate funeral director, Be Certification: To this s after death. in 24 hours ...
the Funeral Director.
`--elv filled in by the fur

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CEREBROVASCULAR autopsy 1□ Yes 2 1 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Universing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 🗌 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide

State

Registrar

completely within 24

Medical

29c. License number

D0059107

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Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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BUSINESS CENTER DRIVE

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

32: Registrar's Signature

07-06459 Lisa Delmedico Physician/ **Medical Examiner**

Funeral

Director

or 28a-f show

Director

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Completed

Be

1- For State

Maryland

11. Marital Status

Widowed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 27839 Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day August 17, 2007 1140 hrs Lisa Kristine Del Medico 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 304 Serenity Court Prince Frederick Calvert 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Months Hours Days 214-90-6161 Country) Virginia 45 1 M 2 X F 03/12/1962 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 304 Serenity Court 20678 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? White, etc. 1 X Never Married 2 Married Yes 1 Yes 2XX No specify: Specify: White Divorced If Yes Give Yeer 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Michael Del Medico Rosemarie Heffron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina King/Sister 1214 Painted Fern Road, Denton, Maryland 21629 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Lakemont orial Gardens Donation 5 Other Specify: 08/21/2007 Davidsonville, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home Short trush 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and failure. List only one cause on each line. Death a endstage chronic obstructive pulmonary disease with complications

Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Physician /Medical

Examiner

Division of Vital Records, P.O. Box 68760, phy: attending or use as t this within 24 hours after death.

To the Funeral Director: completely filled in by the fi

or condition resulting in death)	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	
UNPENDED	AMENDED #1, perME, g870, 8/30/07 TT	
UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unkno Part II. Other significant condition	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregna 4 Pregnant at time of death 5 Other (Specify)	23d. Date of delivery Month Day Year
,	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown 24a. Was an autopsy findings available prior to completion of cause of
		performed? 1 Yes 2 No 1 Yes 2 No
25. Was case referred to medical	26.Place of Death (Check of	only one)
25. Was case referred to medical examiner? 1 V Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursin	g Home 5 Residence 6 🗸 Other: Scene
27. Manner of Death 1 Natural 5 Pending 2 Accident Investig		28d. Describe how injury occurred
1 Natural 5 Pending 2 Accident Investig 3 Sulcide 6 Could n 4 Homicide	28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)

	24a. Was an autopsy performed? 1 Yes 2 ✔ No		
ly	one)	autopsy performed? Yes 2 No 1 Yes 2 No	
Н	ome 5 Residenc	e 6 🗸 Other: Scene	
80	d. Describe how injury	occurred	

August 21, 2007

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

OCME

Name and address of person who completed cause of death (i.e.

and manner stated

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

O.C.M.E.

State Registra

Medical

29a. Certifier (Check only one) 2

29b. Signature and title of certifier

Theodore M. King, Jr., MD.

31. Date filed (Month, Day, Year) 32 Registrar's Signature 3 0

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Aug 24, 2007 **Physician** Margaret Mary Della 5:00A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Severna Park Anne Arundel Genesis Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2XXF 212-01-7431 87 Aug 17, MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2√No Director MD Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21061 USA 602 Old Stage Rd Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: White Specify. þ 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Wade John Paul O'Brien 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2603 Creighton Ave, Balto., MD 21234 Richard D. Della 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition v1. ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dogation 5 ☐ Other (Specify) Aug 28, 2007 Crownsville, MD Crownsville_Vets Cem 21. Si primure di Funer Il Service Lica 22. Name and Address of Facility Fink Funeral Home, P.A. Gregory Kink M01148 426 Crain Hwy S., Glen Burnie, MD Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or contition resulting in death) YEARS CONGESTIVE Due to (or as a consequence of): Sequentially list conditions, any long to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy 1 ☐ Live birth Month Year Day in the past 12, 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To

Physician /Medical Examiner

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page 2

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funeral

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The law requires that the death certificate be executed

the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at

filed within 72 hours after death

2 should be finand Mental h

s 1 and 2 s of Health an item 27 is

Pages 1 ment of H

permit. Pages Department of Important: If it any injury or o

Baltimore, Maryland 21215-0036

1 Yes 2 No

1 Natural 2 Accident

3 ☐ Suicide

4 Homicide

27. Manner of Death

5 Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D3113L

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LO. BALTIMERE UND 21236 KiD 9005 KILBRIDE

31. Date filed (Month, Day, Year) AUG

32. Reistrar's Signature

Registrar DHMH 17 Rev 1/2001

State

Division or Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 10:15 PM Myles William Edwards 21, 2007 August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3400 Bexhill Place Montgomery Kensington If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1**⊠**M 2□F 67 159-32-9404 11/27/1939 PA Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐Yes 2 No MD Montgomery Kensington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3400 Bexhill Place 20895-United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Religion Elementary/Secondary (0-12) College (1-4or 5+) **Episcopal Priest** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mvles William Edwards Ruth Ethelda Cook 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail M. Edwards/Wife 3400 Bexhill Place Kensington, MD 20895-20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition Aug 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2007 21. Signature of Funeral Service Liee 22. Name and Address of Facility M00382 Rapp Funeral & Cremation Services 4D Johnson 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Astrocytoma years /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 5 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2010 1□ Yes Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home XXResidence 6 Other (Specify) 1 Tyes 2XXNo 2 ER/Outpatient 3 DOA ပ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide ***Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature title of certifier MD D0060167 August 22, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Scott Cohen M.D.; 5530 Wisconsin Ave. #930, Chevy Chase, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 3 0 2007

DHMH 17 Rev 1/2001

	Please Type or Pri	nt in Black Indelible Ink.	Ensure All Copie	es Are Legible.
For State Registrar	State of M	laryland / Department of Ho Certificate of D	ealth and Mental H Death	lygiene Reg. No. 2007
1 Decedent's Name //			2. Date of (

		1 - State Registrar		Cert	tificate of	Death	i	Reg. No.	101	2/842
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death certificate be executed estending physician and for use as the burial-transit	/Medical	IF FEMALE:								
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٥		30. Name and address of person who completed cause of	death (Item 23a)	(Туре, Р	Print)	/ / / /			11 . "	28 2007
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	xecute and al-trans	Examiner	that initiated events resulting in death) L		c. Due t	to (or as a cor	nsequence	of):						+	
00100	te be e ysiciar re burik														
00	ertifica ing ph e as th	Medi	IF FEMALE:		00. 1/										
200	attend for us	Physician/Medical	23b. Was decedent in the past 12	months?	1□Liv	outcome pf pr e birth 2 egnant at time	Fetal death		ctopic pregnanc Other (specify) _	ey .		2	3d. Date of Month		Year
į	t the d by the	hysi	1 ☐ Yes 2 ☐ 9 ☐ Unknown	J No	9□Un				., ,,						
cords, r	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral after death. To the Funeral after death. Completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by P	Part II. Other signifi	icant condition	ns contributing to	death but no	t resulting ir	n the und	erlying cause gi	ven in Part I.	1	23e. Did tobacco use contribute to the cause of death? 1			
ב ני	aw rec as beer 2 shou	plete	Pseu	edne y gailure					24a. Was		24b. Were	autopsy findings	available		
	The I	Com	autopsy performed? death? 1 ☐ Yes 2 ☐ No s												
VIC	sician: certific rector,	Be	25. Was case referrexaminer?		Hospital:	- Inneticut	2	to otio et	Oti DOA Oti		eath (Check only				
5	g Physer this er this	7: To	1 Yes 22. Manner of Death	h	28a. Da	☐ Inpatient te of Injury onth, Day Yea	28b. 7	Time of njury	28c. Inju	4 🗀 ivursing	Home 28d. Describe			ресіту)	
200	endin eath. or: Aft	atio	1 ☐ Matural 2 ☐ Accident	5 ☐ Pending investig	ation				M 1	Yes 2 No					
Š	or Att after de Direct in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide	determ	nod 200. Pic	ace of injury - ilding, etc. (S	At home, fa pecify)	ırm, stree	et, factory, office			(Street and own, State,		Rural Route Nun	nber,
	Hospital 4 hours Funeral tely fillec	edical C			Examiner: On the	e basis of exa					ace, and due to the courred at the time				s)
	o the	Med	29b. Signature and	title of certifier		anner stated.			29c. Licen			29d. Dat	e signed (M	onth, Day, Year)	
)	->= o		•		Wart	1	1)		1	47924		8.	27-0	7	
			30. Name and addre		who completed ca	ause of death	(Item 23a) (BY12 N	(Type, Pr	rint)	ADARRID	46				
	Sta Regist		31. Date filed (Mont	th, Day, Year) UG 2 9	2007	Registrar's	Signature	Coar	300		LE			/	
				- 4		A 100-4-	-	1							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 29d per dr., g870,08/30/67/thate of Death Reg. No. 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Jear 15 2007 **Physician** 6:50 P M RUTHIE LOIS /Medical HOLSTEIN 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ROLAND PARK PLACE BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 09/04/1929 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🙀 F 77 Director 220-22-2227 MD Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at Director MD BALTIMORE 1 ☐ Yes 2 ☐ No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9 POMONA NORTH APT, #6 21208

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ Specify: WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit, Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumant HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ **JOSEPH** DRUTZ STELLA MARKOWITZ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACKIE LYNN HOLSTEIN/DAUGHTER 2803 DAMASCUS CT. APT. E - BALTIMORE, MD 21209 Ice of Disposition (Name of 2002) Date 2002. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/27/2007 BALTIMORE, MD AMUNO CONC Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Tetastatic squamuncell lung cancer **Physician** Mentas /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence offe Examiner certificate be executed and burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregrant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Dav Year 4□Pregnant at time of death 5 Other (specify) P.0. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an director, page 2 autopsy performe 1∐ Yes Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Beath (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2000 2 ER/Outpatient 3 DOA Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred 1 Matural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

MESABELLE

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MACREGOR, 830

August 26,2007

N. 40 th Streets Baltunere Ma 21211

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #30, perDVR, C870, 8/30/07 TCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician AUGUST** 2007 5:30A IRIS G. HARR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BRIGHTON GARDENS BALTIMORE BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 👿 F Director 93 <u>273-10-1245</u> 10/02/1913 ΜI Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and the them 27 is marked other than "natural", or items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE BALTIMORE 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1840 REISTERSTOWN ROAD #237 21208 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Mayes 2 □ No ARMY If Yes, Give Year or Dates: WAC 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Completed by 3 Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **HOMEMAKER** OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ PHILIP **GLEICHMAN** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AMY PECK / DAUGHTER 3219 TIMBERFIELD LANE - BALTIMORE, MD 21208 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Department of h Important: If Ite any injury or ot CARROLL CREMATION 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/29/2007 HAMPSTEAD, MD INC. SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Chronic Obstructive pulmonary disease resulting in death) /Medical Due to (or as a consequence of): Examiner Chronic Bronchitis with Emphysema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Hypertensive cardiovascular disease sician and burial-tran Due to (or as a consequence of): Physician/Medical the attending p 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 HInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Chronic renal failure Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS PICE 1 ☐ Yes No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 24 hours after death Prineral Director: filled in by completely within 24

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	64	Sta

29c. License number

Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

Charles S. Angell, MD Brighton Gardens Baltimore, MD

and manner stated.

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4 Homicide

(Check only

29a. Certifier

AUG



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** JOHN SON EVELVN AUGUST 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NORTHWEST HOSF ITAL RANDALISTOWN BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 218-32-7272 1 □ M 2 🕱 F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examlner must be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 Yes 2 No MARYLAND Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? CHICKORY 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 THGRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee FULTON AVE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory rest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIO VASCULAR Physician ATHEROSCLEROTIC /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 □ No 3 ☐ Probably 4 Unknown 1 ☐ Yes plnous 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has t lirector, page 2 s autopsy 2 No To the Hospital or Attending Physician: the funeral director, 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🔲 Inpatient ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Natural 2 Accident within 24 hours after death. To the Funeral Director: A 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 2007

Registrar DHMH 17 Rev 1/2001

State

MICHAEL

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5401

State of Maryland / Department of Health and Mental Hygien ?

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** John S. Johnson, Sr. 29, 12:50AM 2007 August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner 2021 Whistler Avenue n/a Baltimore 8. Date of Birth (Month, Day, Year) 7 / 1 4 / 1 9 4 9 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 1**X** M 2 □ F Days Maryland 58 Director 219-52-6842 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1X Yes 2 □ No n/a Baltimore MD Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2021 Whistler Avenue 21230 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Police Officer City Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth M. Gerlach Robert B. Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2021 Whistler Avenue, Baltimore, MD 21230 Dorothy B. Johnson / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/1/2007 Loudon Park Ceme. Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final **Physician** STOMACH 5 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in list age of the cause). Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last physician and s the burial-tran Due to (or as a consequence of) Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1∐ Yes 2 **N**o 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2**X** No 1 ☐ Yes 2 ER/Outpatient 3 DOA ဥ 1 Inpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVE BALTIMORE MD 21229 AGNES

State Registrar

Division or Vital Records. P.O. Box 68760.

Anthony William Jones

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 27850

	1- For State Registrar		Certificate of	of Death		R	eg. No.	
Physician/ Medical Examine	1. Decedent's Name (First, Midd					2. Date of Dea Month August 26	th Day Year 5, 2007	3. Time of Death 1513 hrs
,	4a. Facility Name (if not institution Prince Georges Hosp			4b. City, Town, Cheverly	or Location of	Death	4c. County of Prince Ge	
Funeral Director	5. Social Security Number 608–20–2177		In yrs. last birthday)		ear If Under ays Hours	24Hrs. 8. Date of Bir Min. 7/21/		Birthplace (State or Foreign FLORIDA Country)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Re Completed by Finneral Director	Usual Residence of Decedent 10a. State 10b. County VA FA 10e. Street and Number 8906 JUDSON (11. Marital Status 1 X Never Married 2 N 3 Widowed 4 Div 15. Decedent's Education (Spe Elementary/Secondary (0-12) 12TH GRADE 17. Father's Name (First, Middle ALFRED WILLIA	COURT 12. Was Decedent Endre Armed Forces? 1	Dc. City, Town or Loca BURKE ver in U.S. 13. W If No 1 eted) 16a. Deceded during Company 19b. Maili 188	ation 10f. Zip Code 220° /as Decedent of It Yes, specify Cub Yes 2 X N ent's Usual Occup most of working If COOK Ing Address (Str. 9 SOUTH osition (Name of It other place)	dispanic Original, Mexican, Ilo specify: sation (Give kinder) 18. Mother's MARIA eet and Numb CAPPER	n? (Specify Yes or Not Puerto Rican, etc.) ind of work done use retired). s Name (First, Middle, A ISABELLA ber or Rural Route Nur RO DR, SAIN	Og. Citizen of What USA 14. Race - White, Specify: 16b. Kind of Bus FOOD Maiden Surname) VASCONCE Ther, City or Town VT AUGUST 20c. Location -	at Country? American Indian, Black, etc. WHITE iness/Industry
Physician 'Medical 'aminer 'I transit	X UNPENDED IF FEMALE: 23b, Was decedent pregnant in the second of the s	b. Due to (or as a consequence on each line. a. Narcotic into Due to (or as a consequence of the consequenc	e death. Do not enter oxication and uence of): uence of): uence of): -f, perME,g8 of pregnancy	521 LOCH the mode of dying d drug use	I RAVEN	N BLVD. TX	OWSON, MI	rt Approximate Interval Between Onset and Death
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring Madical Cartification: To Be Completed by Physician Med	25. Was case referred to medice examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Per 2 Accident Inve	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day, Yea settigation and Indian to be ermined (Specify) Pri- 2hysician: To the best of my the basis of examinar on the basis of examinand manner stated.	2 ER/Outpatie 28b. Time of 28b. Time of 207 28b. Time of 207 29 At home, farm, stance George's knowledge, death occupation and/or investig	26.Pta ant 3 DOA of Injury 28c. In 55 pm 1 reet, factory, office beth Hospital curred at the time gation, in my opin 29c. Lice O.4	Other, on the property of the	1 Ye 24a. Was auto perful Yes Check only one) Nursing Home 5 28d. Describe Unk 28f. Location or Town, Chever ce, and due to the cal.	an 24b. W psy d 2 No 1 Residence 6 how injury occurre (Street and Number State) V. MD se(s) and manner and place, and did 29d. Date signer August 27,	as stated. ue to the cause(s)
<i>N</i> Stat Registra	a 31. Date filed (Month, Day, Year,	32. Redistrar's		Carl .		,		
DHMH 17 Rev 1/200		T COULT TO SERVE	ORIGIN	AL				

			1 = For Amend Items 24a,25 per of	vland / Dep r. ,8870,08 /	artment of Health 30/0/db rtificate of Death	and Mental Hy	giene Reg. No. 201	77 27851
			Decedent's Name (First, Middle, Last)			2. Date of De	ath	3. Time of Death
	Physici		SARAM JONES			Month OR		W 2 8 45 PM
Y	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location		4c. County o	f Death
			MANUR CARE ROLAND PARK		Baltimore			
a	Funeral		1□M 2₩ E	n yrs. last birthday)	If Under 1 Year If Under Months Days Hours	Min. 8. Date of Bir (Month, Date	th ay, Year)	Birthplace (State or Foreign Country)
	Director		011-34-7004	79 Yrs.		Min. (Month, Da July 8	, 1928 S	South Carolina
	and w		Usual Residence of Decedent 10a, State 10b, County 11	Oc. City, Town or Lo	ocation			10d. Inside City Limits
	Aaryli f sho ed af	ŏ	MD	Balti	more			1√2 Yes 2 □ No
	the t	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of Wh	nat Country?
	3a or		4001 Donchester Road		21207		TICA	
	ms 2	Funeral	11 Marital Status 12. Was Decedent Eve	er in U.S. 13.	Was Decedent of Hispanic O	rigin? (Specify Yes or No		- American Indian,
٥	after or ite		Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes, 2 □ No If Yes, Give		If Yes, specify Cuban, Mexica			, White, etc.
2	ral", Exar	j by	3 Widowed 4 Divorced Year or Dates:		1 ☐ Yes 2 X No Specify	.	Specify:	black
2	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during mo	est of working	16b. Kind of Bus	iness/Industry
7	vithin han e.Me	mp	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retired)			
N	iled v Hygie ther t nt, th		3 0	enter	preneuer 18. Moth	ner's Name (First, Middle	Maiden Surname	
anc	e d Hal	Be	George Gray		15.115	tor o realine (r nos, imagic	, wardon ournamo	, unk
2	2 should be filed v and Mental Hygie is marked other t aumatic event, th	은	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street and Numb	ber or Rural Route Numb	er. Citv or Town. S	itate. Zip Code)
<u>8</u>	0 00 50		Sarah Hall/daughter		Donchester Ro			1207
ē,	of Health of Health litem 27 i		20a. Method of Disposition	20b. Place of Dispo		Date		City or Town, State
e E	Pages nent of int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state	cemetery, crei	natory of other place)			
	permit. Pages Department of Important: If it any Injury or once,		Ronald S. Wade, Direct	ctor S	2. Name and Address of Faci tate Anatomy		. Baltimo	re Street
			23a. Part1. Enter the disease, or complications that caused the	Di	altimore, MD	21201 s cardiac or respiratory a	rrest.	Approximate
			shock, or heart failure. List only one cause on each line.				,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Due to (or as a condition of the condition of		ROIOVASCULAR	BLASEICI		
	Examiner			onsequence on.				
	e ^{t)} a	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	onsequence of):				
	be executed sician and burial-transit	Examine	that initiated events C.					
Ď,	e exe ian ar irial-t	Ë	resulting in death) Last Due to (or as a c	onsequence of):				
8/60	the	dical	d					
9	ertific ding p	Med	IF FEMALE: 23c. If yes, outcome pf	n roanenci/				
ROX	leath certific attending p	Physician/Me	in the past 12 months?	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date Mont	of delivery th Day Year
o.	res that the de signed by the a be detached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	ile oi deatii 5				
<u> </u>	that ned by deta		Part II. Other significant conditions contributing to death but r	not resulting in the u	nderlying cause given in Part	1. 23e. Did	tobacco use contrib	oute to the cause of death?
S	quires n sigr ald be	d by	AZZNEMERY DEMENTIA			1 🗆	Yes 2 No 3	B ☐ Probably 4 ☐ Unknown
Records,	w require s been sign should b	Completed	0.0			24a. Was	an 24b. W	ere autopsy findings available
	The lav	шо				auto perfe 1 Yes	ormed? de	ior to completion of cause of eath? □Yes 2□ No
VItal		Be C	25. Was case referred to medical		26. Plac	ce of Death (Check only		163 20110
	Physician: r this certificaral director,	70 E	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3 DOA Other: 4 DA	ursing Home 5 ☐ Res	idence 6 Other	r (Specify)
0	ding Pt h. After tt funeral		27. Manner of Death 28a. Date of Injury 1 ☑Natural 5 ☐ Pending (Month, Day Y	28b. Time o			how injury occurre	
0	Attendii death. ctor: A y the fu	atic	2 Accident investigation		M 1 ☐ Yes 2 ☐			
DIVISION OF	ire ire	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury building, etc. (At home, farm, str Specify) 	eet, factory, office	28f. Location (City or To	Street and Number wn, State)	r or Rural Route Number,
_	pital vurs a eral (ပ္	29a. Certifier 1 Certifying Physician: To the best of r	ny knowledge deat	h occurred at the time, date s	and place, and due to the	course(s) and man	uner as stated
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical	(Check only one) 2 Medical Examiner: On the basis of eyence one) and manner states	kamination and/or in	vestigation, in my opinion, de	eath occurred at the time	, date and place, a	nd due to the cause(s)
	Fo the within Fo the	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed	(Month, Day, Year)
}			hum n.D		D 00591	107	08-10	- 2017
			30. Name and address of person who completed cause of deat	h (Item 23a) (Type,				
					DRIVE REIS	TERSTOWN	mo 2	1136
	Sta		31. Date filed (Month, Day, Year)	Signature	Nº .	-		
	Registr	ar	AUG 3 0 2007	Signature Signature				

State of Maryland / Department of Health and Mental Hygiene Les of Maryland / Department of Health and Mental Hygiene Certer view N. Jacken Section Se	07-06678 Genevieve Niew	iero		pe or Print i							egibl	e.		
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As in this Street As		an/	1. Decedent's Name (First, Midd		Jachen	n				Month	eath Day	Year		. Time of Death
213-12-6469 M 2 21 13 12 14 15 15 15 15 15 15 15	A.			on, give street and n	umber)		-		on of Death		4	c. County of [Death	
Use Breakfast Declared 10st District 10st			5. Social Security Number	6. Sex	7. Age (In yrs. Ia	st birthday)				8. Date of	Birth(MM	I/DD/YYYY) (). Birthp	place (State or
19 19 19 19 19 19 19 19	Director			1 M 2 XF	8.5	5 Yr		Days 110	uis Iviiii.	Sept	23,	1921	Coun	Mary Land
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Priystolian Medical	timent rtant:				St.									
Medical Staminer Talluce List only one cause on each line. Immediate Cause (Final descendance on line) Immediate Cause on line of each line. Immediate Cause (Final descendance) Immediate Cause (Final descendance) Immediate Cause (Final descendance) Immediate Cause (Final descendance) Immediate Cause (Final descendance) Immediate Cause (Final descendance) Immediate Cause (Final descendance) Immediate Cause (Final descendance) Immediate Cause (Final descendance) Immediate Cause (Final descendance) Immediate Cause (Final descendance) Immediate Cause (Final descendance) Immediate Cause (Final descendance) Immediate Cause (Final descendance) Immediate Cause (Final descendance) Immediate Cause (Final descendance) Immediate Cause (Final descendance) Immediate Cause (Final	Bal perm Depa Impo injur		The way	a cicerisae										
Memorar Condition resulting in death Total Condition resulting in death** Death**			23a. Part I. Enter the bisease, or failure. List only one cause	complications that	caused the death.	Do not enter	the mode of d	ying, such a	s cardiac or	respiratory	arrest, sh	ock, or heart	-	
Sequentially list conditions, if any, leading to immediate contributing to death but not resulting in the underlying cause given in Part I. Output Description Desc		Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease												
Part 1. Other significant conditions 22. Feel death 23. Time of Injury 24. May an autopsy findings available prior to completion of cause of centrified 1. Ves. 2 No. 3 Probably 4 Unknown 1. Ves. 2 No. 3 Probably 4 Unknown 2. Part 1. Other significant conditions 2. Part 1. Part 2. Part	X.				a consequence of):								
State		iner	if any, leading to immediate		a consequence of):							\neg	
State	7	xam	(Disease or injury that initiated	c	a consequence of):							+	
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The state of the s	687 ertifica	an/N	23b. Was decedent pregnant in t	ne 1 Live	birth		etal death	3 Ecto	pic pregnan	су	23		•	/ Year
The state of the s	Sox death c	ysic	1 Yes 2 V No 9 Un	death	n	5 0	ther (Specify)							
The state of the s	O. For the set by the etached	۵.	Part II. Other significant condit	tions contributing t	o death but not re	sulting in the	underlying ca	use given in	Part I.	23e. Dio	tobacco	use contribut	te to the	e cause of death?
The state of the s	S, P puires the management of the period	ed b										Last Action		
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The state of the s	Rec : The ificate r, page	흥	25 Was and and an allowed							1 Ye			**)	2 No
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The state of the s	of Ving Ph	١	27. Manner of Death	28a. Date	of Injury	28b. Time of	Injury 28c	Injury at Wo						
29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) August 29, 2007 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 0.0.7 32. Registrar's Signature	Sion Attendi death. ctor:	lgi.		ding stigation										
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29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) August 29, 2007 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 0.0.7 32. Registrar's Signature	Fo the vithin To the comple	edic	one) Medical Exa	miner: On the basis and manner s	of examination an	d/or investiga	tion, in my op	nion, death	occurred at	the time, da	te and pla	ace, and due	to the c	ause(s)
30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 00.7	/	Ž	29b. Signature and title of certifie	/ /					er					, Day, Year)
Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Manyly, Day, Year) 0.0.7 32. Registrar's Signature	9		1 Str	0 - 1		72-1		.U.IVI.E.			Aug	gust 29, 20	JU7	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature							Street, B	altimore,	MD 2120	1				
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DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene, 27853 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** TOBY JASKULSKY AUPUST 16:07 PM 2007 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Paitimore City Sinai Hospital of Bultimore If Under 1 Year | If Under 24 Hrs Months Days Hours Min. B. Date of Birth (Month, Day, Year) 10/07/1919 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 2 K F ntry) MD 219-03-4662 87 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he marifical and once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6317 PARK HEIGHTS AVENUE, APT. #406 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No WHITE Baltimore, Maryland 21215-0036 Specify: þ 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COSMETOLOGIST HECHT COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL FLAX MOLLIE UNKNOWN ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID JASKULSKY / SON 9498 ANGELINA CIRCLE, COLUMBIA, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 ☐Removal from State BNAI JACOB CONG. 08/28/2007 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COPD Physician 10 years disease or condition resulting in death) /Medical Due_to (or as a consequence of): Examiner 10 days Pleural Effusion Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the buriat-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 9 Unknown n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 21 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this c funeral dire 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending within 24 hours are to the Funeral Director Aff 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 AUGUST 26, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 BAILON HOSPIFAL OF Irnai 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

07-06487 Robert Kurtz Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

27854 2007

	-For State Criticate	e of Death	Reg. No.	01 2103
	Registrar 1. Decedent's Name (First, Middle,Last)		Date of Death Month Day Year	3. Time of Death
ledical Examiner	Robert Henry Kurtz, Jr.		August 21, 2007	1710 hrs
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Baltimore	4c. County of Dea	ath
	Bon Secours Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		. 8. Date of Birth(MM/DD/YYYY) 9. E	Birthplace (State or
Funeral Director	5. 5555K, 7.555K, 7.55K	Months Days Hours Min	Fore	eign Country)
	Unknown 1 X M 2 F 36	Yrs.	Sept 8, 1970	MD
Commence of which a second commence of	10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
ž ,	MD Anne Arundel Arnold			1 Yes 2 X No
the Maryland a or 28a-f show	10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	ountry?
the M	1210 Summerwood Ct.	21012	U.S.A.	
er death with t	11. Marital Status 12. Was Decedent Ever in U.S. 1	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto	, , , , , , , , , , , , , , , , , , , ,	erican Indian, Black,
death or iter must	1 Yes 2 XNo		wh:	ite
safter	Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:	Specify: work done 16b. Kind of Busines	s/Industry
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5-0036 ed within 72 hour lygiene. other than "natu the Medical Exar	17. Father's Name (First, Middle, Last)	18 Mother's Name	e (First, Middle, Maiden Surname)	
21215-0036 Mental Hygiene. marked other than ic event, the Medica	Robert Henry Kurtz, Sr.	Nancy Ly Mailing Address (Street and Number or	ynn Diggs	
D 21 hould I hould I dering is made tric eventric 112	Mailing Address (Street and Number of 10 Summerwood Ct. A	Rural Route Number, City or Town, St	ate, Zip Code)	
ME 32 S 12 S 27 ums	RODIN RATUZIENSKI/ SISTEL	Disposition (Name of cemetery,	Date 20c. Location - City	or Town, State
ore, sslar of Her of Her	cremator	v or other place)	_ ~	
Pag Pag ment fant: or ot	4 Donation 5 Other Specify: /	undel Crematory 8-	,	Maryland
Salt vermit Depart mpor njury	21. Signature of Funeral Service, Lice 3	22. Name and Address of Facility Amb 1328 Sulphur Sprin	orose funeral Home	21227
Physician	23 at I. Enter the disease complications that thused the death if o not	enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart	Approximate Interval
/Medical	failure. List only one diuse on each line.			Between Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Complications of chro	onic drug use		
	Sequentially list conditions, b.			
iner	if any, leading to immediate Due to (or as a consequence of):			
Insit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
cuted and transi	d	<u> </u>		
60, ate be execu hysician an e burial - tr	X UNPENDED X AMENDED 27,1 perME.g87	1, 9/15/07 TT		
76C Treate Treate The bu	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deli nancy Month	very Day Year
certif	past 12 months? 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregr Other (Specify)	iditoy	
). Box 687 the death certific by the attending p ched for use as th Physician/	1 Yes 2 No 9 Unknown 9 Unknown			
Records, P.O. Box 68760, The law requires that the death certificate be executed crate has been signed by the attending physician and page 2 should be detached for use as the burial - transit Completed by Physician/Medical Ex	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute	
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that it is after death. "In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacertification: To Be Completed by F				e autopsy findings available
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Records, The law require ficate has been signage 2 should be Completed				Yes 2 No
tal Rection; The certificate ector, page	25. Was case referred to medical examiner?	26.Place of Death (Chec		
f Vit Physic er this cral dire	1 Yes 2 No Inpatient 2 V ER/Out		Residence 6 C 28d. Describe how injury occurred	Other:
ding F	(Month, Day, Year)	ime of Injury 28c. Injury at Work?	280. Describe now injury occurred	
Sion Mitens death ector: by the	2 Accident Investigation	m, street, factory, office building, etc.	28f. Location (Street and Number o	r Rural Route Number, City
Division or spital or Attending tours after death. neral Director: After filled in by the funer Certification:	Suicide 6 Could not be determined (Specify)	m, street, ractory, emac banding, e.e.	or Town, State)	•
C En Portion	29a. Certifier Certifying Physician: To the best of my knowledge, deal	th occurred at the time, date and place, as	nd due to the cause(s) and manner as	stated.
Division of Vital B Division of Vital B To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	one) 2 Medical Examiner: On the basis of examination and/or in	vestigation, in my opinion, death occurred	d at the time, date and place, and due	to the cause(s)
To To To	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed	(Month, Day, Year)
	Albana Brane (MA)	O.C.M.E.	August 22, 20	007
~	30. Name and address of person who completed cause of death (Item 23a)			
Ø	Melissa Brassell, MD Assistant Medical Examiner	111 Penn Street, Baltimore, M	D 21201	
State Registrar	7 2 1 1 2 7 1 1 1 1 1 1 1 1 2 2 2 2 2 2	sare		

ORIGINAL

Physician	
/Medical	
Examiner	

1 - For State Registrar

Funeral Director

the Maryland sa or 28a-f show t be notified at Director death with 23a must Funeral Completed by

permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If filen 27 is marked other the my injury or other trainment.

Physician /Medical Examiner

The law requires that the death certificate be executed nding physician and the Hospital or Attending Physician: After reral Director; filled in by the f

Division or Vital Records, P.O. Box 68760,

within 24 hours a To the Funeral I State

Medical

1. Decedent's Name (First, Middle, Last) 27 2007 AUGUST CHARLES T. KEMP III 12:50a™ 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE BRIGHTWOOD LUTHERVILLE 8. Date of Birth (Month, Day, Year) 06/26/1926 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days Months Hours 1**№** M 2□ F MARYLAND 219-22-9864 81 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No **UPPERCO** MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4340 MT. CARMEL RD 21155 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 ☐ If Yes, Give Year or Dates: 2 □ No 1 ☐ Yes 2 X No Specify. Specify: WHITE 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2YRS EXCAVATING C.E.O. Excavating 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CHARLES T. KEMP JR. BETTY MERRYMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY O, CONNELL (DAUGHTER) 33559 BOB SMITH RD. PARSONSBURG, MD. 21849. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State SHERWOOD 08/31/2007 COCKEYSVILLE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility
HENRY W. JENK
16924 YORK RD W. JENKINS & SONS CO. YORK RD MONKTON, MD. 21111. droil 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chrunic disease or condition resulting in death) Due to (or as a consequence of): Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Sarkinson Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 | Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ H0 24a. Was an autopsy 1∐ Yes 2 C NO 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Lawursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 ∏Yes 2 ∏No 2 Accident 6 Could not be determined

29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAYANT HIRPARA M.D. 7505 OSLER DR. SUITE 509 TOWSON, MD. 21204.

31. Date filed (Month, Day, Year)

3 ☐ Suicide

4 Homicide



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 7 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 17, 2007 10:40 AM Lionarg Aug US/ /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Hospita Secours Birthplace (State or Foreign
Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV 12 6 Sex 7. Age (In yrs, last birthday, **Funeral** Months Days Hours Min 100M 2□ F 216-78-525 1959 Mary Land Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No Director MD N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 514 Manse Court 21201 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 UNK UNK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Clifton Eugene Leonard Virginia Titwell Lee 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Leonard - sister 514 Manse Court, Baltimore, MD21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 8/30/2007 Baltimore, MD 21. Signature of Funeral Service Licenseen 22. Name and Address of Facility of Maryland, Inc. H. Williams 299 Frederick Road, Baltimore, 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medicai Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying clause Unicated or highly that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical as attending properties for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【 No 24a. Was an autopsy 1□ Yes 2 7 funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 70 1 Dimpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending investigation 1 Natural 1 Yes 2 No 24 hours after death. 2 Accident filled in by the 3 ☐ Suicide 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. within 2. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

DHMH 17 Rev 1/2001

07-06615 Richard Liebno Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

· · ·		of Health and Mental H		201	7 (27	85	57
Decedent's Name (First, Middle,Last)			2. Date of Death		3. Time	e of Death	1	1
Richard	Liebno		Month Da August 26, 20	y Year 007	102	20 hrs		
4a. Facility Name (if not institution, give street and numbe	r)	4b. City, Town, or Location of Death		4c. County of Dear	:h			1

Physiciar	n/ ĺ	Decedent's Name (First, Middle,L	ast)				2. Date of Dear		3. Time of Death		
Medical Examin		Richard	T	Month Day Year 1020 hrs							
		4a. Facility Name (if not institution, o		Liebno		City, Town, or Location	7.0903t 20, 2007				
		828 Berrymang Lane	,			Reisterstown	Baltimore County				
Funeral		Social Security Number 6.	Sex 7. Age	(In yrs. last	birthday)	If Under 1 Year If Und	der 24Hrs. 8. Date of Bir	th(MM/DD/YYYY) 9. Bir	thplace (State or		
Director		220-48-0487	X M 2 F	56	Yrs.	Months Days Hou	re Min	Foreig			
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E		Usual Residence of Decedent 10a. State 10b. County		10d. Inside City Limits							
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faryland 28a-f show Latonce.	힑	MD Baltim	ore	Keis	tersto						
Man Man r 28a	2						0g. Citizen of What Cou	ntry?			
th the M		828 Berrymans	Lane			21136		U.S.A.			
12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp							rigin? (Specify Yes or No	 14. Race - Amer White, etc. 	ican Indian, Black,		
deat or it	<u>.</u>	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No									
	2		ed If Yes, Give Year or Dates:			es 2 X No specifi		Specify: Whi			
3036 within 72 hours iene. er than "natur Medical Exam	8	15. Decedent's Education (Specify				Usual Occupation (Give of working life. DO NO		16b. Kind of Business/	Industry		
16 n 72 nan "	Completed	Elementary/Secondary (0-12)	College (1-4 or 5-	+)		oloyed		I In om	n l avva l a		
21215-0036 and be filed within 7 Mental Hygiene Marked other than cevent, the Medica	Ĕ.				onem				ployed		
Hygi d oth	ပ္ကို	17. Father's Name (First, Middle, La					er's Name (First, Middle, I	Maiden Surname)			
21215 hould be fill and Mental H is marked utic event, t	8	Vernon H. Lie					orothy Cox				
Should Mand M	의	19a. Informant's Name/Relationship Dottie Collins	(Sister)			•	mber or Rural Route Num	•	e, Zip Code)		
MD ng 2 sho arth and m 27 is	. 14		(pracer)	Took Dies		n (Name of cemetery,	ad Chester	<u> </u>	Tarra Chata		
Baltimore, MD 2 semit: Pages 1 and 2 shoul Department of Health and In Important: If item 27 is in njury or other traumatic.		20a. Method of Disposition 1 Burial 2 X Cremation	Removal from Stat		natory or other		Date	20c. Location - City or	rown, State		
		4 Donation 5 Other Speci			o Crema	atory	8-29-2007	Catonsville	e, MD		
Baltir permit. P Departme Importai		21. Signature of Funeral Service Lic	ers Funeral	Directors,							
w 59 11	1	21. Signature of Funeral Service licensee 22. Name and Address of Facility Loring Byers Funeral Dispose Road Randallstown, MD 2									
Physician		2/a. Part I. Enter the sease, or cor	mplications that caused the	ne death. Do	not enter the	mode of dying, such as	cardiac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and		
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xaminer		or condition resulting in death) Due to (or as a consequence of):									
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c 68760, I certificate be exe ending physician a use as the burial	달	IF FEMALE:	AMENDED 27, per	n'IL,g8/	1, 9/15/0	J/ TT		23d. Date of deliver	<u> </u>		
87(tifica ng phas the	틹	23b. Was decedent pregnant in the	1 Live birth		2 Fetal	death 3 Ector	oic pregnancy		y Day Year		
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Box e death the atter ed for u	Physic	1 Yes 2 No 9 Unkno	wn g Unknown			and the second second					
P.O.	<u>~</u>	Part II. Other significant condition	s contributing to death	but not resul	Iting in the und	erlying cause given in F		obacco use contribute to			
cords, P.O. Box	d b						1 Yes	S 2 No 3 Pro	bably 4 🗸 Unknown		
Division of Vital Records, and or Attending Physician: The law requirers after death. al Director: After this certificate has been si led in by the funeral director, page 2 should the control of the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director and the funeral dir	24a. Was an autopsy finding prior to completion death? 1 V Yes 2 No 1 V Yes 2										
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Division To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the fi	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Solve the control of the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Solve the control of the cause(s) and manner as stated. Solve the control of the cause(s) and manner as stated. Solve the control of the cause(s) and manner as stated. Solve the control of the cause(s) and manner as stated. Solve the control of the cause(s) and manner as stated. Solve the control of the cause(s) and manner as stated. Solve the control of the cause(s) and manner as stated. Solve the control of the cause(s) and manner as stated. Solve the control of the cause(s) and manner as stated.										
	O.C.M.E. August 27, 2007										
	ansite of										
	-	30. Name and address of person wh	o completed cause of de	ath (Item 23	a)	<u> </u>					
			o completed cause of desistant Medical Exa			Street, Baltimore,	MD 21201				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6:30 p^M FRANCES A. LEE 24 2007 August 4a. Facility Name (If not institution, give street and number) 4c. County of Death JOSEPH RICHEY HOSPICE BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 □ M 25 XF 212-34-0393 MARYLAND JUL 4 1935 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 428 N PATTERSON PARK AVENUE 21231 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ŽNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify Specify: 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th grade BARMAID/TENDER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ARTHUR LEE GRACE C MURDOCK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linden Ave., Pleasantville, NJ., 08232 Allen N. Lee/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XX urial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) 4 Donation MD NATIONAL CEMETERY 08-30-07 LAUREL, MARYLAND Signatur of Funer Service Licen 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown

Physician /Medical Examiner

permit. Pages 1 Department of H Important: If ite any Injury or ot once.

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

a or ms 23a Director

Completed by

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show

event, the Medical

Baltimore, Maryland 21215-0036

physician a the burial attending p signed by certificate has been s rector, page 2 should funeral director, After this after death.

Division or Vital Records, P.O. Box 68760.

5175

Examine Physician/Medical þ Be Completed Medical Certification: To

25. Was case referred to medical examiner?

23b. Was decedent preg in the past 12 men 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

29a. Certifier

31. Date filed (Month, Day, Year)

23e. Did tobacco use contribute to the cause of dea. 1 ☐ Yes 2 ☐ No 3 Probably

Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1□ Yes 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

6 Could not be determined 3 Suicide 4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number

30. Name and address of person o completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State Registrar

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within 24 hours aff
To the Funeral D
completely filled in

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 7: 07 M Robert Edward Lacher Dec 1 trupui /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs.

Days Hours Min. Homore Washington Medical Conter Mounds 6. Sex 1₩M 2□ F 8. Date of Birth (Month, Day, Yes 4/17/1927 Birthplace (State or Foreign Country)
 MARYLAND Social Security Number 7. Age (In yrs. last birthday) **Funeral** 213-22-1354 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show 1 ∐Yes 2X No Director MD ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 208 4TH AVENUE S.W. Funeral 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 12 December 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. illed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) STORE KEEPER PAINT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be h and Mental CHARLES LACHER MARY SCHULTZ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is AMY J. LACHER - WIFE 208 4TH AVENUE S.W., GLEN BURNIE, MD 21061 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department o Important: If any Injury or Injury or CHESAPEAKE CREMATION 8/30/2007 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD 21. Signal 22. Name and Address of Facility SINGLETON FUNERAL HOME P.A. 1 2ND AVE. S.W., GLEN BURNIE, MD 21061 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Carcinona 1 d day disease or condition resulting in death) 0100 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a ☐Yes 2☐No 9□ Unknown 9 HInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 ☑ No 1 🗀 Yes 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1. Inpatient 2 1 TYes 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident I or Attend after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ineton Medica Center

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

AUG 3 0

2007

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month O 8 **Physician** Leroy J. Levee 25 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Hospital Baltimore 01 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. Nov 1, 1933 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ₹M 2 □ F 219-28-9827 73 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at MD Harford 1 ☐ Yes 2√ No Bel Air Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 514 Westview Road 21014 Funeral IISA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Armed Forces:
1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates: 150-56 Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify Specify: White þ 3 Widowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natur any injury or other traumatic event, the Medical. once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) litigation analyst Social Security Adm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leroy J. Levee Sr Thelma Henshaw 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Edwards/daughter 423 Chestnut Hill Road Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Sta 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signa Service Licensee Wade Ronald S <u>Baltimore, MD</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ perlipidemia pertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ After thi 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation within 24 hours are to the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8, 25, 2007 000

State Registrar

Stephen 31. Date filed (Month, Day, AUG

Year)

0

Smai Hospital of Baltimore 2401 W. Belvedere Ale Billing MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32 Registrar's Signature

Amend Item 24a per verb., g870,08/30/04bb Reg. No. 27861 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month August 15, 2007 Margaret Moore 12:30 AMM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Eastpoint Nursing & Rehab Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛱 F Yrs. 245-30-3730 Director 80 Mar 10, 1927 South Carolina Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 23a or 28a-f show the Medical Examiner must be notified at 1√ Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 S. Chapel Street 2 should be filed within 72 hours after death wand Mental Hygiene. 21231 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status unk Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any lighty or other traumatic event 9DRB. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eastpoint Nursing & Rehab Ctr 1046 Old Northpoint Road Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑Donation 5 ☐ Other (Specify) 21. Signature Euraral Service Licensee Wade Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician /Medical Examiner stape Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes No Hospital: ဥ 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) batwood Rd 7845 Ste IND rardon 31. Date liled (Month, Day, Year) 32. Registrar's Signature State AUG 3 0 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 27862 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0910 M ,200 LUCILLE WALDEN MEEKS /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UNION MEMORIAL HOSPITAL BALTIMORE 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🛛 F Director 76 NORTH CAROLINA 219-26-8475 JUNE 18 1931 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f shor the Medical Examiner must be notified at Director 1 XYes 2 No MARYLAND N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2604 GUILFORD AVENUE 21218 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ŽNNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2XXXNo Specify. ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC ENGINEER 8th grade HOUSEKEEPING 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe and Mental WALTER ALSTON JENNIE BELL ALSTON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a permit. Pages 1 and Department of Health Important: If item 27 any Injury or other to once, Mildred Meeks/Daughter 4312 Plainfield AVe., BAltimore, Maryland 21206 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State MXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08-30-07 KING MEMORIAL PARK BALTIMORE, MARYLAND 21. Signature of Funer Service Lice 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Part1. Enter the disease, or conshock, or heart failure. List only clications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MULTIPLE MYELDMA meraus /Medical Due to (or as a consequence of): Examiner unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ANEMIA Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by DEMENTIA 1 | Yes 2 | No 3 | Probably 4 Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an , page 2 s performed (25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation or Attending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident death 24 hours after death Funeral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29b. Signature and title-of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8/25/0 DO059056 MO 30. Name and address of arson who completed cause of death (Item 23a) (Type, Print) Salyc Falls RS 3612 32. Régistrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 Registrar

			= For State Registrar	State of Maryl 27,29a per dr/d	and / Depa lvr, 870,0	rtment of H B/30/07db dificate of t	lealth and N Death	/lental Hygi	iene eg. No. 20	07 27863
	Physici		Decedent's Name (First, Middle, La	st)	M.			2. Date of Death		3. Time of Death
	/Medic	al 🤄	Amaya	a street and number	Na	VARTO	Location of Death	Hugust	4c. County of	w _j
	Examin		4a. Facility Name (If not institution, given the South NS 5. Social Security Number 6. S	HOPKINS HO	Spital yrs. last birthday)	Baltir If Under 1 Year	nore If Under 24 Hrs.	8. Date of Birth	N/A	9. Birthplace (State or Foreign
*	Director		214-67-1550	□ M XX F 4	Yrs.	Months Days	Hours Min.	June 2,		Country) Maryland
	land ow t		Usual Residence of Decedent 10a. State 10b. County	10c.	. City, Town or Lo	cation				10d. Inside City Limits
	Mary a-f sh ified a	ctor	Maryland Baltim	ore	Roseda	le	_			1 ☐ Yes 2 💆 No
	or 28 be not	Dire	10e. Street and Number			10f. Zip Code 2123	3.7	10	Og. Citizen of Wh	nat Country? States
	ns 23a must	Funeral Director	8820 Trimble Way	12. Was Decedent Ever i	in U.S. 13. \	Vas Decedent of H	ispanic Origin? (Si	pecify Yes or No-	14. Race -	- American Indian,
036	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1		fYes, specify Cuba I⊡KYes 2⊡No	Consitu	rican, etc.)	Specify:	White, etc. White
21215-0036	d within 72 hours after death with the Marylan glene. I than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	1 (Give	tent's Usual Occup kind of work done DO NOT use retired	durina most of wor		16b. Kind of Busi	iness/Industry
7	e filed wi Il Hygier other th		n/a 17. Father's Name (<i>First, Middle, Last</i>	•)	n	./a	18. Mother's Nan	ne (First, Middle, M	Maiden Surname	
Maryland	be de de de	To Be	Carlos Navarro	,				ipe Jonap	,	,
ary	sh mand		19a. Informant's Name/Relationship	(Type. Print)	19b. Mailir	ng Address (Street				tate, Zip Code)
	s 1 and 2 of Health item 27 is			(Father)	8820 b. Place of Dispo	Trimble	Way Ros	sedale, M		21237 Dity or Town, State
סר			20a. Method of Disposition	Removal from State	cemetery, crer	natory or other place leart of				, Maryland
Baltimore,	permit. Page Department of Important: If any injury or once.		4 □ Donation / 5 □ Other (Speci 21. Signatur / Juneral Salvice Lice	1 1 11	22 D	2. Name and Addre	ss of Facility Funeral	Home of	Dundalk	, Inc.
			23a. Part1. Enter the disease, or con	nplications that caused the		922 Wise er the mode of dyir				Approximate Interval Between
	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a cor	reath					Onset and Death
	Examiner			Brain	10	riation	1			24hours
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co-	rsequenne of):					
ó,	cate be executed oblysician and the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cor	nsequence of):					
8760,	icate b physic s the bi	dica		_d						
O. Box 6	The law requires that the death certificate be executed tae been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome pf pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date Mon	of delivery th Day Year
ecords, P.O.	w requires that to be a signed by should be detact	þ	Part II. Other significant conditions Crouzon 5		t resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	\ /	bute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
r	The law recate has bee page 2 short	Completed		<u> </u>				24a. Was a autops perfor	sy pr med? de	/ere autopsy findings available rior to completion of cause of eath? ☐ Yes 2 No
or Vital R	ician; Th certificate ector, pag	Be C	25. Was case referred to medical examiner?			704		ath (Check only or	ne)	
<u>_</u>	Physion this cral dire	은	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatier	IL OLI DON		lome 5 ☐ Reside	ence 6 □Othe	
Ou	ding h. After funer	tion	1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Yea		Wo	rk?]Yes 2 □ No	Log. Boodings (A	on mjar, ocoamo	
Division	or Atter fter dea Director in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide		At home, farm, str pecify)	reet, factory, office		28f. Location (S City or Tow	treet and Numbe n, State)	er or Rural Route Number,
_	To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director After this certifica completely filled in by the funeral director, to	- F	(Check only Modical Eye	hysician: To the best of my iminer: On the basis of exa and manner stated.	mination and/or in	vestigation in my	opinion, death acc	urred at the time of	date and place, a	and due to the cause(s)
	To th withir comp	Me	29b. Signature and title of certifier	1 am extrano		29c. Licens	se number) 63275	2	29d. Date signed AUZUS	(Month, Day, Year) + 17, 2007
	0		30. Name and address of person who	completed cause of death with MD 60	(Item 23a) (Type,	Print St.	Battin	iore, Mi	2128	7
	St Regist	ate rar	29b. Signature and title of certifier MANNE 30. Name and address of person who MANSSO-Bruk 31. Date filed (Month, Day, Year) AUG 3 0 201	32. Registrar's S	Signature	dis.				

State of Maryland / Department of Health and Mental Hygien 2007 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 Month 425 **Physician** HILANYNUGENT (I)M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Cromwell Center Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 ₹ M 2 □ F Days unk Director 76 Mar 6, 217-26-3593 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State is then "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Baltimore Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8710 Emge Road 21234 USA Funeral 12. Was Decedent Ever in U.Sunk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other then "natural" or Iter 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white δ 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk other treumetic event, 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 Is in any injury or other treum once. Cromwell Center 8710 Em e Road Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 □Donation 5 ♥Other (Specify) in state 21. Signature of Euneral Ser Remail S. Wade / Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5EP515 WEEK **Physician** /Medical Due to (or as a consequence_of): PUEUMONIA ASPIRATION **Examiner** WEEK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine OROPHARYNGEAL CANCER the attending physician and hed for use as the burial-transit requires that the death certificate be executed MONTH resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ANEMIA 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c, Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred e Hospitel or Attending P 24 hours after death. e Funeral Director: After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours an 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number ٥ F. Seledo my ク32 チリチ BALT. MD 21234 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EN TEN Year) 8710 EM6E 31. Date filed (Month, Day, Year)
AUG 3 0 2007 FER NANDO 32 Aegistrar's Signature State Joules Registrar

				State of Maryland / Department of Health and Maryland / Department of Health And Maryland / Department of Health And Maryland / Department of Health And Maryland / Department of Health And Maryland / Department of Health And Maryland / Department of Health / Department of Health / Department / Depar	lental Hygie	2007	27865
				1. Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
•		Physici /Medio		Audrey R. Putty	August	16 Zoo 7	0457 AM
		Examir	ier	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death City of Bull of	51	4c. County of Death	1
		Funeral Director		5. Social Security Number 6. Sex 1 Months Days Hours Min.	8. Date of Birth Month, Day, You Dec 8, 1	9. Birth 946 Mary	nplace (State or Foreign Intry) Land
1		iand ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
#		the Marylar 28e-f show	ctor	MD Baltimore			1√ Yes 2 No
2		death with the Maryland ms 23a or 28e-f show I must be notified at	Funeral Director	106. Street and Number 10f. Zip Code 4001 Clarks Lane #309	10g	. Citizen of What Cou	intry?
2	-	ter death w Items 23a	eral	11 Marital Status 12. Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	USA 14. Race - Amer	
die	5-0036	after or Ite	b	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No	Rican, etc.)	Specify: b1	
A	15-0	thin 72 hours e. an "natural", Medical Exe	Completed	15. Decedent's Education (Specify only highest grade completed) [Specify only highest grade completed)	ing 16	b. Kind of Business/li	ndustry
Sh	2121	d within giene. r than "	dmo	Elementary/Secondary (0-12) College (1-4or 5+) teacher advisor		education	
	pu	be filad ttal Hygie d other	Be		e (First, Middle, Mai	iden Surname)	
MM	Maryland	should be nd Menta markad umatic ev	ပ္	David W. Putty mary R 19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number or Rura</i>	Jones	Thurs Town State 7	in Code)
Khown		1 and 2 sho Health and em 27 is m		Angela Putty/sister in law 8260 Streamwood Drive			208
	altimore,	nit. Pages 1 and 2 should be filad wil artment of Health and Mental Hygien ortant: If item 27 Is marked other th injury or other treumatic event, Its is.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 200	c. Location - City or T	own, State
Phient	Balti	permit. Pages. Department of P Important: If ite any injury or of		21. Signature of Emeral Service Licenses Ronald S. Wade, Director State Anatomy Board Baltimore, MD 2120		Saltimore	Street
_		e.		2 a. Part1. Inter the disease, or compilitations that caused the death. Do not enter the mode of dying, such as cardiac of shock, it heart failure. List only one cause on each line.	or respiratory arrest		Approximate Interval Between Onset and Death
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		acuted ind transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): CLIVE ON VASCULAY C. Due to (or as a consequence of):	nt		Iday
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	x 68	leath certificat attending phy I for use as th	Medi	IF FEMALE:			
7	P.O. Box	Attending Physicien: The law requires that the death certifica rideath. r death. ector: After this certificate has been signad by the attending ph potor: After this certificate has been signad by the attending phy the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delive Month	very Day Year
#82	Division of Vital Records, P	n requires that the death been signad by the atte should be detached for	ed by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dru Betes Mellitus type II	23e. Did tobac	2 No 3 Pro	the cause of death?
, ,	eco	e law re has bee je 2 sho	nplet	huper tension	24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
	al B	iclen: The l certificate ha rector, page		Blyolar	performed 1 ☐ Yes 2 €		21 No
	Vit	ysicler s certil directo	To Be	examinar? Hospital: Other	n (Check only one) me 5 □ Besidenc	e 6 □Other (Speci	ifv)
	n of	ding Phys	on: T	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how		
	/isio	Attendir death.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined by the state of Injury - At home, farm, street, factory, office		et and Number or Rui	ral Route Number,
	Ó	urs afte		□ Dullding, etc. (Specify)	City or Town, S		
		To the Hospital or Attending Physicien: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a company one examination and/or investigation, in my opinion, death occurred at the time, date and place, a company one examination and/or investigation, in my opinion, death occurred at the time, date and place, a company one examination and/or investigation, in my opinion, death occurred at the time, date and place, a company one examination and/or investigation, in my opinion, death occurred at the time, date and place, a company one examination and/or investigation, in my opinion, death occurred at the time, date and place, a company one examination and/or investigation, in my opinion, death occurred at the time, date and place, a company one examination and/or investigation, in my opinion, death occurred at the time, date and place, a company one examination and/or investigation, in my opinion, death occurred at the time, date and place, a company of the company o	and due to the caus ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	\	To t To t	Σ	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month	, Day, Year) 7002
				30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0 0	1	, 000 7
				Julie Philley, MD Sinai Hospital C 31. Date filed (Month, Day, Year) 32. Registrar's Signature	H Bal	timore	
		Sta Registr		AUG 3 0 2007 August J. Aug			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 27866 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** 74:25 PM **JENNIFER PETERSON** 2007 bug ust /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER HARFORD BEL AIR If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 258-65-8688 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🛛 F 35 11/20/1971 Director ΜI Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at MD HARFORD ABINGDON 1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 707 ROYAL MILE DRIVE 21009 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No WHITE ≥ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SPECIAL EDUCATION TEACHER 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) alth and Mental Hygiene. 27 is marked other than er traumatic event, the M EDUCATION 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event Be LLOYD FOX LENORE WEINSTOCK ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT PETERSON / HUSBAND 707 ROYAL MILE DRIVE - ABINGDON, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW 4 Donation 5 Dother (Specify) 08/31/2007 REISTERSTOWN, MD. SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physiclan espirator 10 hours /Medical Due to (or a a consequence of): Examiner John + Respiratory
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Lymphangitie 5 sician and burial-trans Box 68760. attending physician for use as the buris Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. been signed by the should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy etic certificate LDC Attending Physician: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 npatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Di Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0053568 August 25. 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upper Chesapeo 1extra 31. Date filed Month, Day, 32 Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 8:09 P M AUG 28 2007 JUANITA ALLEEN RIDENOUR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY NATIONAL NAVAL MEDICAL CENTER BETHESDA If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Days **Funeral** 1 □ M 🗶 🗓 F Months Hours 287 14 8605 87 920 Ohio Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits with the Maryland 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2X☐XVo Princ Gorge's Clinton MD Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number United States 8702 Pinta Street 20735 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner miner once. by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married X Married 1 ☐ Yes 2 ☐ NO Baltimore, Maryland 21215-0036 White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 2^{College (1-4or 5+)} Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fae C. Markel William C. Martin ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Paul W. Ridenour (Husband) 8702 Pinta Street, Clinton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ cremation 3 ☐ Removal from State Lee Crematory Sept 5, 2007 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, . Inc 6633 21. Signature of Fune at Service 70015 01d Alexandria Ferry Road, Clinton, MD20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** STROKE disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or irgury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attention newsivian and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 XNo 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 X Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of codifier D63136 -, MA Aug. 29, 2007 NATIONAL NAVAL MEDICAL CENTER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 BETHESDA MD 20889-5600 RICHARD T. MAHON CDR MC USN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 3 0 2007 Registrar

			For State	State of Marylar					200	7 2706
			1 - State Registrar Amend #18, per 1. Decedent's Name (First, Middle, Last)	FD, G8/0, 8/30/	07 TP-	unicate of	Dealli	2. Date of Dea		
	Physici	an						Month	Day Year	3. Time of Death
Ę.	/Medic		Elsie M. Robbi			4L City Town	at analise of Dooth	Aug.	30 2007	
10	Examir	er	4a. Facility Name (If not institution, give s	· · · · · ·			r Location of Death		4c. County of Dea	
1000	and a second and a second		Carroll Hospice 5. Social Security Number 6.				inster If Under 24 Hrs.	8. Date of Birtl	Carro	11 thplace (State or Foreign
	Funeral Director			M 2 DXF 91	Yrs.	Months Days	Hours Min.	(Month, Day	v, Year) C	ountry)
			Usual Residence of Decedent					June .	28,1916 M	aryland_
	yland Iow at		10a. State 10b. County	10c. Ci	ity, Town or Lo	ocation				10d. Inside City Limits
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	h with	ᇛ	1393 Hughes Sho	op Rd.		2115	8		U.S.A.	
	deat ms 2	Funeral Directo		12. Was Decedent Ever in U Armed Forces?	J.S. 13.		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Am	
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yla	ould Mer parke	ဥ	James Thomas G					Buckr		
9	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. If marked other than "natural", or Items 23a or 28a-f show deher traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Ty	•					er, City or Town, State,	
	1 and 2 Health em 27 l		Linda Dennis -			Hughes				MD. 21158
5	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R	}	cemetery, crei	nsition (ivame of matory or other plac	ce)	Date	20c. Location - City of	r Town, State
	Tant:		4 ☐ Donation 5 ☐ Other (Specify)	Dr					⁷ Pikesvi	
20	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service License) e	22	2. Name and Addre	iss of Facility Ec	chardt	Funeral	Chapel P.A
	<u>~</u> □ = @ 0		J. Darth helld	<i>\dagger</i>	1	<u>1605 Re</u>	isterst	own Rd.	. Owings	Mills, MD.
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F	Physician		Immediate Cause (Final disease or condition			5-05	2			Onset and Death
	/Medical		resulting in death)	Due to (or as a consec	quence of):					
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/	icate be executed physician and the burial-transit	Kam	that initiated events resulting in death) Last	Due to (or se a come	muonoo ofi:					
5	oe ex	<u>—</u>	, , , , , , , , , , , , , , , , , , , ,	Due to (or as a consec	quence ar):					
5	cate to the company of the company o	dical	o d							
			IF FEMALE:	0. 1/						
	death certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf pregn 1☐Live birth 2☐Feta	aldeath 3[Ectopic pregnancy	y		23d. Date of de Month	elivery Day Year
5	ne de the a hed f	/sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of o	death 5L	Other (specify) _			, monar	ouy rou
	Attending Physician: The law requires that the death certif refeath. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Ph	Part II. Other significant conditions cor	stributing to death but not res	sulting in the re	nderlying cause giv	on in Part I	23a Did to	bacco use contribute t	o the cause of death?
<u>ק</u>	res t signe	by	Tarris out or organisative organisms out	and any to doubt but not rec	salang in the a	riderlying dause giv	en in raiti.	1 🗆 Y		robably 4 Unknown
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<u>.</u>	e law	nple						24a. Was a autop	sy prior to	utopsy findings available completion of cause of
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	Ing F	on:	27. Manufer of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor		28d. Describe h	low injury occurred	
5 .	tend eath. tor: / the fi	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No			
-	irec n by	Certification:	4 Homicide determined	28e. Place of injury - At h building, etc. (Speci	iome, farm, str ify)	eet, factory, office		28f. Location (S City or Tow	Street and Number or F vn, State)	lural Route Number,
ָ נ	urs al									
	Hosp 4 hou Fune Tely fi	ical	(Check only 2 Medical Examin	sician: To the best of my knoner: On the basis of examination	owledge, deat ation and/or in	h occurred at the til vestigation, in my o	me, date and place, opinion, death occur	and due to the or red at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft coπpletely filled in by the fur	Medical	one)	and manner stated.						
ı	5 4 kit	2	29b. Signature and title of certifier	om (ma	RIMO	29c. Licens		1	29d. Date signed (Mon	in, Day, Year)
				(9	V -		2005994		August	30,2007
	V		30. Name and address of person who co		, , , , ,		1025	16-3		
	*	_		1M) 295	-	/ Av. 5	1VIT 507	rest	minster 1	10 017
	Sta	7.7	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature '					

Registrar

AUG 3 0 2007

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 Amend Item 23a per dr., g870,08/39/07 bettilicate of Death 27869 1. Decedent's Name (First, Middle, Last)
DORO'17+Y
M 3. Time of Death Month Year **Physician** 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner STEPHENS COURT UpT. 10 CILY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday)

Yrs. 5. Social Security Number 6. Sex 14,1925 **Funeral** 1□ M 21 F Days PENNSYLVANIA 217-20-8435 Usual Residence of Decedent Director 10d. Inside City Limits 10c. City, Town or Location 10b. County Department of Health and Mential Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Funeral Director MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No Specify: BLACK Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Baltimore, Maryland 2121 Elementary/Secondary (0-12) SELF-EMPLOYED METOL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be DAYLOR ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ANDALLSTOWN MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 SON FOREST 08-27-07 OWINGS MILLS, MB 22. Name and Address of Facility 2140 N. FULTON AVENUE 21217 3 ☐Removal from State 1 Burial 2 □ Cremation 4 ☐ Domation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Joseph H. Brown, Jr. Funeral Home Balhmore MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or pearl failure. List only one cause of pach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) colonary value Physician /Medical Examiner Unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine pe executed burial-transit Due to (or as a consequence of); Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 Other (specify) P.O. 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Thura, Hypertension, Chronic 2 No 3 Probably 4 Unknown Be Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Arthritis Rheumatoid, 24a. Was an autopsy performed? 1 Yes 2 No or Vital 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) funeral director, Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Mannel of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury Division or Attending **Natural** 5 Pending investigation n 24 hours after death.
the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide Hospital tacertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) completely To the I within 24 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 21 200)

State Registrar

2600 31. Date filed (Month, Day, Year) AUG 3 0 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2600 laberty hts are, Boltowole MD besty ave. hts

32. Registrar's Signature

			For State	S	tate of M	larylan		artment of F				-		27870
	L TALE		Registrar 1. Decedent's Name (First, M.	iddle, Last)			001	tillcate of	Death		2. Date of De	Reg. No. ath		3. Time of Death
	Physici		Regina	Maria	2 5	imo	nons				Month S	Day Z C		7 11:15 PM
	/Medic Examin	_	4a. Facility Name (If not instit	ution, give stre	et and number		, , ,	4b. City, Town, o	r Location o	of Death			County of Death	1
		ŧ _		ount	1		tospita	Colo	mlni	a			Hawa	W.
	Funeral	.12.4	5. Social Security Number	6. Sex 1 ☐ M	1	ge (<i>In yrs.</i> i 33	la <i>st b</i> irthday) Yrs.	Months Days	If Under Hours	Min.	8. Date of Birl (Month, Da 4/19/1	th y, Year)	Cot	nplace (State or Foreign untry)
and the	Director	b	216-18-6242 Usual Residence of Deceden								4/13/1	724	IV.	aryland
	yland now at		10a. State 10b. Co.	,		10c. City	y, Town or Lo	cation						10d. Inside City Limits
	e Mar 3a-f sl tified	Director	MD Ba.	ltimore	:	Ba	altimo	re						1 ☐ Yes 2 📆 No
	vith th	Dire	10e. Street and Number					10f. Zip Code	07				zen of What Co	untry?
	eath v is 23a must	eral	8 Palo Court	12	Was Deceden	t Ever in 11	S 13	212		igin? (Snec	cify Yes or No		JSA 14. Race - Amer	ican Indian.
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. It of Health and Mental Hygiene. It is marked other than "natural" or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ □ 3 □ Widowed 4 □ Divo	Married	Armed Forces 1 Yes 2 The Street of Yes, Give Year or Dates:	? No	- 1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:		Rican, etc.)		Black, White Specify:	
2-0	72 hou	Completed	15. Dece (Specify only hi	dent's Educati	on ompleted)		16a. Dece	dent's Usual Occup	ation	st of workin	а	16b. Ki	nd of Business/I	ndustry
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2	iled w Hygier her th		12 17, Father's Name (<i>First, Mid</i>				Cash:	ıer	18 Mothe	er's Name	(First, Middle,		Retail F	00d
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Z	and 2 should salth and Mer n 27 is marke	은	19a. Informant's Name/Relat	ionship (Type.	Print)		19b. Mailir	ng Address (Street					r Town, State, Z	ip Code)
Ž	1 and 2 Health a tem 27 is		Richard T. Sin	nmons,	Jr. / S	Son		Elm Road	•	timor	ce, Mar	ylar	nd 21227	
e.	es 1 a of He fitem		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremat	on 3 🗆 Bam	oval from State			osition (Name of matory or other plac	ce)		ate		ocation - City or	
Ĕ	Pages Iment of I Iant: If its jury or o	. 3	4 Donation 5 □ Othe	r (Specify)		Mt.	1 = 1	et Cemete	-	8/30/				Maryland
Baltimore.	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra		21. lignature of Funeral Ser	Os	2		4		ns Av	enue,	Balti	more.		Inc. and 21229
			23a. Part1. Enter the diseas shock, or heart failure.	e, or complicat List only one o	ions that cause cause on each	ed the death line.	n. Do not ent	ter the mode of dyir	ng, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		Sege								
7	Examiner		, , , , , , , , , , , , , , , , , , , ,		Due to (or a	s a co <i>n e</i> qu	uence of):							
	">60 sh	je.	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b	Due to (or a	s a cons <i>e</i> q	uence of):							
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0	ate be executed hysician and the burial-transit		resulting in death) Last	8	Due to (or a	s a consequ	uence of):							
8760		dical		d										
9 x	Yeath certific	/Me	IF FEMALE:	23c.	If yes, outcom	e pf pregna	ancy						23d. Date of deli	verv
Box	death e atter d for u	Physician/Me	23b. Was decedent pregnan in the past 12 months? 1 Yes 2 No		1□Live birth 4□Pregnant			∃Ectopic pregnancy ∃ Other <i>(specify)</i> _	/			1	Month	Day Year
0	t the c by the	hysi	9 ☐ Unknown		9□Unknown									
Division or Vital Becords. P.O.	To the Hospital or Attending Physician: The law requires that the death certifications after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	by P	Part II. Other significant cor	ditions contrib	outing to death	but not resi	ulting in the u	nderlying cause giv	en in Part I	l.				the cause of death?
ord	requir een s hould	ted		<u> </u>								Yes 2[_	
3ec	e faw has b	Completed	_ OSt	opra	133						24a. Was autoj	DSV .	24b. Were au prior to death?	topsy findings available completion of cause of
9	n: Th ficate or, pag		25. Was case referred to me	dical					00 81	- (D 1)		rmed2 2∐No	1 ☐ Yes	2 No
5	/sicla	o Be	examiner?	Hos	pital: tu inpat	tient 2∏	ER/Outpatier	nt 3 DOA Oth	or:		(Check only o		6 □Other (Spec	nifv)
o	g Phy ter this neral c	n: To	27. Manner of Death		28a. Date of In	jury	28b. Time o				8d. Describe			ony)
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Σį	or Att fter de direct n by t	Certification:		uld not be termined	28e. Place of ir building, e	njury - At ho etc. <i>(Specif</i>	ome, farm, sti y)	reet, factory, office		2	8f. Location (City or To	Street an wn, State	nd Number or Ru e)	ral Route Number,
	pital ours al	2	29a. Certifier 1 Cert	ifvina Physici	an: To the hes	t of my kno	wledne deat	h occurred at the ti	me date a	nd place, a	and due to the	cause(s)	and manner as	stated
	e Hos 24 hc e Fun etely	Medical				of examina		vestigation, in my						
	To the Hospital or Attending Physician: The law requires that the dewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Me	29b. Signature and title of ce	rtifier				29c. Licens	e number		T		te signed (Monti	
	0		Misas	ati	MC)		D	00643	72			8/26,	167
	120		30. Name and address of per											
			Misalati, MD 31. Date filed (Month, Day, 1)	5755		ane, traris Signa		oja. Mary	land	2104	14			
	Sta Registi		S. Date filed (Mortal, Call)	302	UU	300								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend 19a.perFD, g871, 9/11/07 TT Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 23, 2007 **Physician** Genevieve Sandow 5:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Elizabeth Nursing Home Center Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/12/1910 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 X 213-10-1631 97 Louisiana Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State notified at 1 ☐ Yes 2 No Director Baltimore MD Baltimore 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? If them 27 Is marked other than "natural", or Items 23a or or other traumatic event, the Medical Examiner must be a 3310 Benson Avenue, #125 21227 United States Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. nt: If Item 27 Is marked other than "natural", or Items 23 Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify White Completed by Specify. 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be f Health and Menta Adelaide Pritchard John Lawrence Dupuy 19a. Informant's Name/Relationship (Type. Print) Sandow Mr. James Dandow (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1500 Langford Road, Gwynn Oak, Maryland 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or oth 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory Baltimore, Maryland 08/23/2007 tion 5 Other (Specify) 21. Son ture f Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) emen **Physician** ears /Medical Due to (or as a consequence of): Examiner nort Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as IF FEMALE: use a 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectonic pregnancy for in the past 12 months? 1 ☐ Yes 2 2000 Month Day Year 4□Pregnant at time of death ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be d Completed by 010 1 Yes 2 No 3 Probably 4 No nknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy 2 No Sertificate 1☐ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one, Certification: To Be 1 Yes 2 No Hospital: Other: 2 ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 □ Residence 6 □ Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1XX) Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

ours after death.

neral Director: A
filled in by the for within 24 hours a

To the Funeral I

completely filled To the Hospital

29a. Certifier 1 💆 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore IND 20 verrue enson 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

AUG 3

Registrar DHMH 17 Rev 1/2001 200

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007

			State of Ma		ertificate of		nd Mental H	ygiene 2 () Reg. No.	07 27872
DI		1. Decedent's Name (First, Middle, La	ist)		10		2. Date of D		3. Time of Death
Physi /Med		Ann Conyers	Semans				Augus	t 29 2	OO7 2:25 pm
Exam		4a. Facility Name (If not institution, given				•	n, or Location of Dea		
		Blakehurst Life (Towso			timore
Funera Directo		5. Social Security Number 6. 9 213-58-4446 Usuat Residence of Decedent	Sex 7. Age 1 □ M 2 🗹 F	(In yrs. last birthda) 82 Yrs.	Months Days		Min. 8. Date of E (Month, I APR 2.	l 1925	9. Birthplace (State or Foreign Country), Bermuda
land ow		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
Many Frsh	ō	MD Baltin	nore	Towson					1 □ Yes 2/CNNo
r 28g	Director	10e. Street and Number		20,110012	10f. Zip Code	-		10g. Citizen of \	What Country?
h wit	a D	1055 W. Joppa Ro	ad		21204	,		Bermu	da
dea	Funeral	11. Marital Status	12. Was Decedent Example Forces?	ver in U,S. 13.	Was Decedent of	Hispanic Origin	n? (Specify Yes or N Puerto Rican, etc.)	lo- 14. Rac	e - American Indian, ck, White, etc.
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of Z 1 Z 1 3-UUZU filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23e or 28e-f show ent, the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	edent's Usual Occu e <i>kind of work done</i> DO NOT use retin	ipation e du <i>ring most</i> o	f working	16b. Kind of Bi	usiness/tndustry
withii ene.	μř	Elementary/Secondary (0-12)	College (1-4or 5+)	maker	30)		Own Ho	me
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ld be ental ced o	To Be	Gerald G. Co	nyers			Wini	fred Ma	ud Ste	vens
shou nd M mari	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mai	ling Address (Stree	t and Number	or Rural Route Num	ber, City or Town,	State, Zip Code)
INI and 2 alth a 27 is		Nancy S. Talbott	- daughter	825	Wellin to	on Road	, Baltimo	re. MD	21212
othe othe		20a. Method of Disposition		20b. Place of Disp cemetery, cre			Date		City or Town, State
Page nent c		1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Con		Metro Cr			8/30/07	Baltim	ore, MD
partitioney, Ivially Idinal ZIZIS-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at		21. Signature of Funeral Service Lice	ven H. Will	iams	2. Name and Addr Cremation	ess of Facility on Soci	ety of Ma Road, Bal	ryland,	Inc.
6	.,	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused tone cause on each line						Approximate Interval Between Onset and Death
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ruted d ansit	Examiner	Sequentially list conditions C	b	ue to (or as a conse	iduence off.				
cate be executed physician and the burial-transit	lical Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	ue to (or as a conse	quence of):				
box of any of authoring properties as it	an/Mec	L	d						
that the death certific ed by the attending p	/ Physician/Medical	Part II. Other significant conditions of	ontributing to death but	not resulting in the	underlying cause g	iven in Part I.		tobacco use co	ntribute to the cause of death? 3 □ Probably 4 □ Unknown
Physician: The law requires that the death certifications are signed by the attending priral director, page 2 should be detached for use as	Completed by							s an autopsy formed?	24b. Were autopsy findings available prior to completion of cause of death?
The I	Š						10	Yes 21 No	1 ☐ Yes 2 ☐ No
ian: artifice ctor, I	Be	25. Was case referred to medical examiner?					f Death (Check only	one)	
hysic nis ce I direk	10	1 Yes 2 No	Hospital: 1 Inpatient		ent 3LI DOA		ing Home 5□Re	sidence 6 □Oth	er (Specify)
l or Attending Phys after death. Director: After this		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	Wo			how injury occur	red
Attending or death.	cati	2 Accident investigatio			M 1]Yes 2□No			
after d Direct	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		y - At home, farm, s <i>(Specify)</i>	treet, factory, office			(Street and Numb own, State)	er or Rural Route Number,
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical Ce	29a. Certifier (Check only one) 29a. Certifying Pt 2	nysician: To the best of niner: On the basis of e and manner state	xamination and/or in	nvestigation, in my	opinion, death	occurred at the time	e, date and place,	and due to the cause(s)
To the within To the compl	Me	29b. Signatule and title of certifier	n		29c. Licen	se number 5830	3 VSON N	29d. Date signe	d (Month, Day, Year) 29 2007
12		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type	Print) MARICS S	it To	VSON N	0212	04
	tate	31. Date filed (Month, Day, Year)	32. Registrar		1				
Regis	trar	AUG 3 0 2	2007 Lateres	J. 15 14	and				

			For State Registrar	State o	of Mary	land / De	partme <i>ertifica</i>			and Me	ental Hy	giene Rea. No	200	7 27873
	∘ Physici		1. Decedent's Name (First, Middle, Dorothy Mary	^{Last)} Streake	r	<u> </u>					2. Date of De Month			3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, g		,			, Town, or	Location of		ugust	40	. County of De Howard	
- 000	Funeral Director		5. Social Security Number 213–18–9621	. Sex 1 □ M 2 ½ F	7. Age (In 86	yrs. last birthd Yrs	Months	Per 1 Year Days	If Under Hours	Min.	B. Date of Bir (Month, Da	rth ay, Year)	(irthplace (State or Foreign Country)
	faryland show ed at	or	Usual Residence of Decedent 10a. State 10b. County Howard		100	e. City, Town or West F		ship						10d. Inside City Limits 1
	with the Na or 28a-1	Director	10e. Street and Number 13990 Frederick	Road			10f. Z	p Code	<u></u>			10g. Cit	tizen of What (Λ
ဖ	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural" or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Dec	orces? 2 □LNo	in U.S.	It Yes, sp	edent of H	ispanic Ori an, Mexicar	gin? (Spec n, Puerto R	ify Yes or No ican, etc.)		14. Race - An Black, Wh	nite, etc.
Maryland 21215-0036	72 hours 'natural', o	eted by	3 Widowed 4 Divorced 15. Decedent's (Specify only highest	If Yes, Gi Year or D Education grade completed)	ates:	16a. De	1 ☐ Yes cedent's Us ive kind of w e. DO NOT	A ual Occup	Specify: ation during mos	t of working	7	16b. K	Specify: What ind of Busines	
12121	iled within Hygiene. ther than ' nt, the Me	Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, La	+2	1-4or 5+)	1	hool b		ontra	ctor	First, Middle		nsporta	tion
ryland	2 should be to and Mental I is marked of raumatic ever	To Be	Albert Hofmann	,		19h M	ailing Addres	s (Street	Rose	М. В	etz		or Town, State	Zin Codel
	s 1 and 2 s Health an tem 27 is other trau		19a. Informant's Name/Relationship Elizabeth Streat 20a. Method of Disposition	ker Bush		ob. Place of Di	ondon	derry	Dr.		ton, M	D 21		
altimore,	Per Int		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lie	cify)	State 1	Mt. Vie	w Ceme	tery	8	-29-0				ille, MD & Chapel
Ba	permit. Departr Imports any int		▶ Paige Haight	Herbe			P.O. E	ox 1	95 Sy	kesvi	11e, M	1D 2:		-
·	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	nly one cause on e	each line.	nd Hand standard		20	_		respiratory a	errest,		Approximate Interval Between Onset and Death
The same	Examiner	ler	Sequentially list conditions, if any, leading to immediate	b. ———		nsequence of):		_						
oʻ	icate be executed physician and s the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a co	nsequence of):								
68760,	tificate be ig physici as the bu	ledical		d	5							_		
.O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		birth 2 🗆 nant at time	Fetal death	3 □Ectopic p 5 □ Other (s			-			23d. Date of d Month	elivery Day Year
rds, P	w requires that s been signed b should be dete	þ	Part II. Other significant conditions	,	leath but no		underlying	cause give	en in Part I.					to the cause of death? Probably 4 □Unknown
al Records,		Completed									24a. Was auto perfo 1∐ Yes		prior to death?	
r Vital	ysician is certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ №	Hospital: 1 □	Inpatient	2 ☐ ER/Outpa	tient 3□ D	OA Othe	or:		<i>Check only o</i>		6 Other (Sr	pecify) AFFT. Living
o uo	ding Ph h. After thi funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat			28b. Tim		28c. Injun Work		28	3d. Describe			iciny)
Division or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not determine	· Later	e of injury - ing, etc. <i>(S</i> j	At home, farm, pecify)	street, facto			-	f. Location (City or To			Rural Route Number,
	he Hospit in 24 hours he Funera pletely fille	ca	(Check only 2 Medical Ex	Physician: To the caminer: On the b and man	pasis of exa	mination and/o	r investigatio	n. in mv o	pinion, dea	th occurred	d at the time.	date an	d place, and d	ue to the cause(s)
	Voith Com	Σ	29b. Signature and title of certifier	- 116			29	c. License	number 3/3/	6		29d. Da	te signed (Mo	nth, Day, Year)
7	15		30. Name and address of person wh	no completed caus	se of death	(Item 23a) (Typ	pe, Print)	wter	- On	·	Cotrole	in ,	ust a	044
	Sta Registr	te ar	29b. Signature and title of certifier 30. Name and address of person where the second	2007 32.	egistrar's S	Signature	Gostle	,						· ·

State of Maryland / Department of Health and Mental Hygien 2 1 1 7 27874 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Vear Ellsworth Edward Somerville 5:35a 2007 28 /Medical August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester 5. Social Security Number 7. Age (In yrs. last birthday) tf Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 M 2 ☐ F 89 220-03-4840 Director Yrs. June MD 1918 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County or 28a-f ahow 10d. tnside City Limits the Medical Examiner must be nutified at MD Carroll Westminster Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 631 Holliday Lane 21157 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 ☐ No If Xes, Give Year or Dates: 1 ☐ Never Married 2 X Married 21215-0036 natural, or WWII 1 ☐ Yes 2 🕅 No Specify: Specify: white ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) television technicial electronics 12 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Ellsworth Somerville Helen Brohm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Importent: If Itam 27 ia any injury or other trau Bessie Somerville (spouse) 631 Holliday Ln., Westminster, MD 21157 DOD OS. Baltimore, I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-1-07 Sykesville, MD All County Cremation 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service License Dugestaiges s ensent P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) myocardial in Du (or as a consequence of): **Physician** infarction /Medical Examiner Sequentially list conditions, if any, beauting to immissing cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): .0. Box 68760, Due to (or as a consequence of) Physician/Medical ed by the attending property of detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day Year 5 ☐ Other (specify) 9□ Unknown 30 a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>ک</u> bradycardia 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Vital or Attanding Physicien: funeral director, 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 270 1 ☐ Yes 2 No 1 SInpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending after death. М 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funerel C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) than the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ran Egmond Mo D0056307 August 28, 2007 30. Na le and address of p son who completed cause of death (Item 23a) (Type, Print)

J. van Egmond MD, Atlantic General Hospital, 9733 Healthway Drive, Berlin, MD 21811 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

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	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death	Day Your	3. Time of Death
	/Medi		Ethel Rita Sullivan			August 10	, 2007	7:59 AM M
4	Examir	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dea		4c. County of Death	
			4209 Farragut Street #1 5. Social Security Number 6. Sex 7. Aq	- //	Hyattsville		Prince Ge	
в	Funeral Director		578-54-5088	e (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birth	place (State or Foreign intry) UNK
			Usual Residence of Decedent	70		08/19//	928	
	nylan how		10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	e Ma	cto	MD Prince George's	Hyattsv	ville			1 ☐ Yes 2 No
	or 28	<u>S</u>	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cou	ntry?
	72 hours after death with the Maryland netural', or Iteme 23a or 28a-1 ahow dical Examiner must be notified at	Funeral Director	4209 Farragut Street #1		20781		USA	
	er de	nue	11. Marital Status unk 12. Was Decedent Armed Forces?		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White,	
36	rs aft	by F	1 Never Married 2 Married 1 Yes 2 X If Yes, Give Year or Dates	10	1 ☐ Yes 21 No Specify:		Specify: whi	
우	hou	edt	3 Widowed 4 Divorced Year or Dates:	163 Doog	dent's Usual Occupation	101		
15	n n	Completed	(Specify only highest grade completed)	(Give	kind of work done during most of wo DO NOT use retired)	rking	o. Kind of Business/Ir	ndustry
27	d within giene. rrthen	E	Elementary/Secondary (0-12) College (1-4or 5 unk	+)	waitress		restara	unt
פ	be filed ital Hygi d other event,	Be C	17. Father's Name (First, Middle, Last)	, , , , , , , , , , , , , , , , , , , ,	unk 18. Mother's Na	ne (First, Middle, Mai	den Sumame)	unk
<u>a</u>	should b nd Menta marked	To E						
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental hygiene. Item 27 Ie marked other then "netural", or items 23a or 28a-1 ahow other traumatic event, the Mcdical Exercities I. was the notified at		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number or Ri	ural Route Number, Ci	ty or Town, State, Zij	Code) unk
	and lealth m 27 hsr tr		Sgt Bergling/City of Hyatts		731 4 1			
altimore,	of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place)	Date 200	. Location - City or To	own, State
Ē	Pag ment ant: ury c		4 □Donation 5 🛛 Other (Specify) in state					
Ball	permit. Pages in Department of Hamportant: If the any njury or of ODEs.		21. Signature of Eureral Service Licensee		Name and Address of Facility Late Anatomy Boar Litimore, MD 212		altimore S	Street
			23a. Pant. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not ente	er the mode of dying, such as cardia	or respiratory arrest,		Approximate
	Physician	14	Immediate Cause (Final disease or condition	trice O.	A Annah	- C4 .		Interval Between Onset and Death
	/Medical		resulting in death)	a consequence of):	or this day	m		1
	Examiner	Ш	Sequentially list conditions, b.				-	"Linuinge
	שָּׁי עַ	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):				
	and and -trans	Examiner	that initiated events C.					
8760,	be ex cien burial	E	Due to (or as a	consequence of):				
87	The law requires that the death certificate be executed site has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dicat	d					
9 ×	w requires that the death certific been signed by the attending p should be detached for use as	by Physician/Me	IF FEMALE: 23c. If yes, outcome	of pregnancy	NA			
a	atter for u	clan	in the past 12 pronths?	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
o.	y the	ysi	1 Yes 2 No 4 Pregnant at 9 Unknown	anne or death 3	Cities (specify)		NIA	
Division of Vital Records, P.O. Box	that	ם	Part II. Other significant conditions contributing to death bu	t not resulting in the un	derlying cause given in Part I.	23e. Did tobacc	o use contribute to the	he cause of death?
S	quires n sign	۵ ا	Hypertension,	Seiswo	- disorder	1 □ Yes	2 No 3 Prob	pably 4 Unknown
S	w rec	Completed	hypo Man dia	140		24a. Was an	24h Mara auta	and findings are lable
æ	he la e has age 2	E	Jon Jos Gro	VV		autopsy performed	prior to co	psy findings available mpletion of cause of
<u>a</u>	in: T	80	25. Was case referred to medical			1 ☐ Yes 2 X		2 No
>	/slcia s cert direct	To B	examiner? 1 ☐ Yes No Hospital: 1 ☐ Inpatier	nt 2 ER/Outpatient	Othor	th (Check only one)		
ō	eral o	<u>-</u>	27. Manner of Death 28a. Date of Injur	28b. Time of	28c. Injury at Work?	28d. Describe how in	6 ☐Other (Specification)	ν)
0	ath. T: Aft	atio	f Natural 5 ☐ Pending (Month, Day	Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		. ,	
<u>S</u>	Atte	Certification;	3 Suicide 6 Could not be determined 28e. Place of Inju	ry - At home, farm, stre	eet, factory, office	28f. Location (Street	and Number or Rura	al Route Number,
ā	s after	Sert	4 Homicide building, etc	. (Specify)		City or Town, St	ate)	
		Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state.	examination and/or inv	occurred at the time, date and place estigation, in my opinion, death occu	, and due to the cause rred at the time, date :	e(s) and manner as si and place, and due to	tated.
	ithin ; o the	Me	29b. Signature and title of certifier.	eu.	29c. License number		Date signed (Mgnth,	
	F 3 F 8		1 AAAS MIN			18	9/1/	7
		-	30. Name and address of person who completed cause of de	ath (Itam 22a) /Time 5	52706	, , , ,	410/	0/
			ASHENAFI WAKTOLA	MD 58	of Baltimore 1	tue Hyali	tselle 140	2078/
	Stat Registra	~	31. Date filed (Month, Day, Year) AUG 3 0 2007	rs Signature				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 20 A M 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sev Birthplace (State or Foreign Country) **Funeral** 1 ▼ M 2 □ F Director 579-52-5339 85 May 8, 1922 Switzerland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Prince George's Director Adelphi 1 ☐Yes 2√☐No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1808 Metzerott Road #15 20783 by Funeral USA death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Intent of Health and Mental Hygiene.
Int Item 27 is marked other than "natural", or iten
Iny or other traumatic event, the Medical Examineer.
Iny or other traumatic event, the Medical Examineer. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 hotels 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gottfried Siegenthaler 2 Lina Muller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trai Stephanie Siegenthaler/spouse 1808 Metzerott Road #15 Adelphi, MD 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑Donation 5-Other (Specify) permit. 21. Signature of Funeral Service Licensee Ronald S. Wade, 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MĎ 21201 23a. Part1. Enter the disease or commodations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. It is only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): discare Examiner relas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence on The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2[4 No P 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospita to ... within 24 hours after death.

To the Funeral Director: After the Funeral Director After the Funeral Director After the Funeral Filled in by the funeral Filled in Director After the Funeral Filled in Director After Funeral Filled in Director After Funeral Filled In Director A 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of per on who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 26, 2007 12:30 p M MALCOLM L. TUSING August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Greater Baltimore Medical Center Towson 8. Date of Birth (Month, Day, Year) 3/20/1926 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 1X M 2 F Months Days Hours Min MARYLAND 212-22-9814 Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits 1 ☐ Yes 2 No MD Director HARFORD **JOPPA** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 720 MAGNOLIA ROAD 21085 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. ty∏Yes 2 ☐ No If Yes, Give Year or DatesKOREAN 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) SOCIAL SECURITY Elementary/Secondary (0-12) College (1-4or 5+) INVESTIGATIVE CLERK **ADMINISTRATION** 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) THOMAS F. TUSING BEULAH MAY CROFT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDNA M. TUSING/WIFE 720 MAGNOLIA ROAD JOPPA, 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State LORRAINE PARK CEM. 8/30/2007 4 □ Donation 5 □ Other (Specify) WOODLAWN, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. art. Enter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Seizure daxs HVDDXIG Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con equence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav 5 ☐ Other (specify) 1 □ Yes 2 □ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2DNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ☐ ER/Outpatient 3 ☐ DOA ည 1 TYes 1 mpatient 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation M 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division

Hospital or Attending

death.

within 24 hours

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Funeral

Director

rai", or items 23a or 28a-f show Examiner must be notified at

'natural", or

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event

Physician

/Medical Examiner

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the Funeral Director: After thimpletely filled in by the funeral

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29a. Certifier

29b. Signature and title of certifier

21215-0036

Baltimore, Maryland

68760,

Box

P.0.

or Vital Records,

DHMH 17 Rev 1/2001

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1an q

32. Registrar's Signature

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and manner stated.

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Char

LCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

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	hysici: /Medic		1. Decedent's Name (First, Middle, Last)	Tyson				2. Date of Death	L, 2007	3. Time of Death 1.30 P M
1.	xamin		4e. Facility Name (If not institution, give s 4602 Fairvicw			4b. City, Town, or	Location of Death	i i	4c. County of Death	4
	neral ector		5. Social Security Number 6. Sex 213-60-2638 1	M 2017. Age (In yrs. las		If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Birth	ptace (State or Foreign intry)
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with the A	Le notifi	Funeral Director	10e. Street and Number 4602 Fairvien	Ave.		10f. Zip Code	212-16	10g	. Citizen of What Cou	intry?
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d 21215-0036 filed within 72 hours af Hygiene.	The Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give ki	ONOT use retired	lurina most of wor	king 16 Echnician	city of	Baltinore
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and 2 should bealth and Men	er treuma		19a. Informant's Name/Rela ionship (Type Carla Tyson-o	laughter	19b. Mailing 6313	Address (Street a	nd Number of Ru Place	ral Route Number, C	ity or Town, State, Zi Ballimor	. 11. 1.
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Demit.	any injudical		21. Signature of Funeral Service License	Parken	.00	Name and Addre	of Facility Par derick	Kerture Ave. Bay	ial Home timore, N	6.A. 21229
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DIVISION OF VITAL To the Hospitel or Attending Physician: within 24 hours after death.	completely filled in by the funer		4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)		•		City or Town, S	·	
he Hospitel	pletely fi	edicai	29a. Certifier 1 L Certifying Physical (Check only one)	cian: To the best of my knowle er: On the basis of examinatio and manner stated.	edge, death on and/or inve	stigation, in my op	e, date and place, inion, death occur	, and due to the caus rred at the time, date	e(s) and manner as s and place, and due t	stated. to the cause(s)
To the within 2	two com	Ž	29b. Signature and title of certifler	to, M	0	29c. License	3804	I .	Date signed (Month,	Day, Year)
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۵	To the Hospital or Attend within 24 hours after death To the Euneral Director; completely filled in by the f	ledical Cer	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of onliner: On the basis of ex	xamination and/o	eath occurred at the t rinvestigation, in my	ime, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and date and plac	manner as s	tated. o the cause(s)
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	- » - O		> September	MD		PE	55-000		August	-23,	2007
	3		30. Name and address of person who	completed cause of deal	th (Item 23a) (Typ	of Baltin	we				
	Sta Regist		31. Date filed (Month, Day, Year) AUG 3 0	32. Régistrar's	s Signature	Coole					

			1 - For State Registrar	State of Ma	ryland / I	Depa <i>Cei</i>	artment of rtificate of	Health <i>Deatl</i>	and M h	ental Hyg	iene	2007	27880
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	Examir		4a. Facility Name (If not institution, giver Carroll Hospital				4b. City, Town,	or Location			4c. C	County of Death	h
	Funeral Director		5. Social Security Number 6. S 216-05-5039		(In yrs. last bii 93	rthday) Yrs.	If Under 1 Yea Months Days	r If Unde	er 24 Hrs. Min.	8. Date of Birth (Month, Day, Oct 7,	Year)	9. Birti	nplace (State or Foreign untry) MD
	Aaryland I show	ō	Usual Residence of Decedent 10a. State 10b. County MD Capro		10c. City, Tow Mt	n or Lo							10d. Inside City Limits 1 Yes 2 No
	with the Na or 28a-	Funeral Director	10e. Street and Number 6621 Buffalo	Road			10f. Zip Code	771		10	Og. Citizo	en of What Co	
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yland	a la b	To Be C	17. Father's Name (First, Middle, Last) Charles Unverza					18. Moti	her's Name	(First, Middle, N	faiden S		
펼	0 0 0		19a. Informant's Name/Relationship (Mr. Gary Unvers		196	. Mailin	g Address <i>(Str</i> ee Triade)	t and Numi lphia	ber or Rura Road	Route Number, Ellicot	City or	Town, State, Z.	ip Code) 21042
Imore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemete	гу, сгөп	sition (Name of natory or other pla y Cremat					ation - City or 1 esville	
Pall	permit. Departi Import any inj		21. Signature of Funeral Service Licer	Houget ,	40076	1 22 1 S	Name and Add AIGHT FU ykesvil	JNERA Le, M	L HOMI D 2178	E & CHAP 34 (410	EL,		Box 195)
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	vithin 24 hours and the Funeral completely filled	Medical	29a. Certifier (Check only one) 2 ☐ Medical Examone) 29b. Signature and title of certifier	ysician: To the best of iner: On the basis of ex and manner state	kamination and	, death dor inve	estigation, in my	opinion, de	nd place, as ath occurre	d at the time, dat	e and pl	lace, and due t	o the cause(s)
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07-06572 Michael Wood

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Funeral Director	4	5. Social Security Number 6. S 218-94-5178 1		yrs. last b 28	irthday) Yrs.	If Under 1 Yea Months Day			Date of Birth	,		lace (State or ry) MD
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2 hours after "natural", o	rune	1 X Never Married 2 Married 3 Widowed 4 Divorce 15. Decedent's Education (Specify Elementary/Secondary (0-12)	Armed Forces? 1 Yes 2v If Yes, Give Year or Dates:	No	1 1 2 3 a. Decedent's during mos	s, specify Cubar Yes 2 X No s Usual Occupa st of working life	specify:	rto Rica	n, etc.)	Specify 6b. Kind of	nite, etc. y: Whi Business/Ind	te ustry
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica		11 17. Father's Name (First, Middle, Las Michael Ste	,		Labo			enda	Ann L	aiden Surnar aWSON		
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Baltimore, oernit. Pages I and Department of Heal Important: If iten injury or other tra		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other Special	y:		atory or other	ion (Name of ce er place) Mem. Pa	ark 8,		2007	Syke	sville	, MD
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ires that the de signed by the	2	Part II. Other significant condition	contributing to death bu	t not result	ting in the ur	derlying cause	given in Part I.	_				e cause of death?
Division of Vital Records, P.O. Box 68. To the Hospital or Attending Physician: The law requires that the death certifully thin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as completely control of the control of	Completed							- [24a. Was ar autops perform 1 Yes 2	y ned?		psy findings available inpletion of cause of
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Di To the Hospital of thin 24 hours a To the Funeral I completely filled	dica	one) 2 Medical Examin	cian: To the best of my kner:On the basis of examina and manner stated.	owledge, on and/o	death occurre or investigation	ed at the time, don, in my opinion	late and place, n, death occurre	and due ed at the	to the cause time, date a	(s) and man nd place, an	ner as stated d due to the	cause(s)
	M	29b. Signature and title of certifier	ul , miD.			29c. Licen: O.C.	M.E.	_		29d. Date s August 2	igned (Montl 25, 2007	n, Day, Year)
$\tilde{\mathcal{V}}$		30. Name and address of person wh Donna M. Vincenti, MD	Assistant Medical			Penn Street	t, Baltimore	MD 2	1201			
Stat Registra		31. Date filed (Month, Day, Year)	37 Registrar's S	ignature	food	e						

			State of Maryland / Department of Health and I 1 = State Registrar Amend Items 24a,25,27,29a per dr. as 40,08630/0741bth	Mental Hygie Reg.	ne N 2007	27882	
			1. Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death	
*	Physici /Media		Margaret Williams	August 10	Day Year 7 2007	7:00 PM M	
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	h	4c. County of Deat		
			Prince George's Medical Center Cheverly		Prince Ge		
∯r.	Funeral Director		5. Social Security Number 135-46-0590 6. Sex 1 M 2 F F F F F F F F F F F F F F F F F F	8. Date of Birth (Month, Day, Ye Dec 26, 1	ear) Co	hplace (State or Foreign untry) gia	
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	h with	al D	117 Milburn Street 27807		USA	•	
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21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hyglene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Yes 2 ☒ No Specify:	o nican, etc.)	Black, White		
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Ž	should be ind Mental marked c	2	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Ru	ine McLain	ity or Town State 1	in Code)	
Ma	and 2 s ealth an n 27 is er trau		Davis Walker/son P.O. Box 723 Battlebo			ip Code)	
lore,	Pages 1 al nent of Hea ant: If Item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)		c. Location - City or	Town, State	
Baltimore, Maryland	permit. Pages 1 an Department of Heal Important; If Item 2 any Injury or other once.		4 □Donation 5 Mother (Specify) in state 21. Signature of Funeral Stryice Licensee Ronald S. Wade Frector State Anatomy Board	1 (55			
<u> </u>	89 = 88		Ronald S. Wade Frector State Anatomy Board Baltimore, MD 2120	d 655 W. B	altimore	Street	
n			23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Caronay arey disease	e		Onset and Death WCVIIS	
	/Medical Examiner		Due to (or as a consequence of):			1112 Mc	
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	icate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Pure to (or so a consequence of)			doeps	
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68760,	physi physi s the i	edical	d			gears	
Box (IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy		23d. Date of deli	ven	
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000	aw require s been sig s should b	olete	Henalitei	24a. Was an	24b. Were au	topsy findings available	
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/ital	ician; Th certificate ector, paç	Be (examiner:	th (Check only one)			
0	Physi this o	2		ome 5 Residence		eify)	
UC C	ding Phys h. After this funeral dir	ion:	27. Manner of Death 1 Natural 5 □ Pending (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 4 Work?	28d. Describe how it	njury occurred		
Division or	death ctor: y the	icat	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office	28f. Location (Street	t and Number or Ru	ral Davita Number	
N N	ital or A	Certification:	4 Homicide building, etc. (Specify)	City or Town, Si	tate)	,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, to	edical	29a. Certifier (Check only one) 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place	, and due to the cause rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)	
29b. Signature and Me of certifier 29d. Date signed (Mont							
			James M. Cyllian MD 194534	Au	gust 10, 20	07	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Ac. X.	1 010	ad un	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	11/1/2011	LICARO.	119/11	
*	Registr		AUG 3 0 2007	•			

			1- For State of Mary		artment of H rtificate of L		lental Hygier	7 6 1 1 1 1	27883						
ı	Physici		1. Decedent's Name (First, Middle, Last) Douglas Conrad Williams				2. Date of Death Month August 28	Pay 200 ⁷ 200	3. Time of Death 3:15 P M						
nt black	/Medie Examir		4a. Facility Name (If not institution, give street and number) Good Samaritan Nursing Home		4b. City, Town, or Ba.	Location of Death		4c. County of Death							
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In 103–18–6908 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	n yrs. last birthday) 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 05/19/1920	ar) Cou	place (State or Foreign ntry) ryland						
	Maryland f ehow	or		Oc. City, Town or Lo	cation estminster				10d. Inside City Limits 1 ☐ Yes 2 ☐ No						
	3a or 28s	Funeral Director	10e. Street and Number 321 Stoner Avenue		10f. Zip Code 21157		10g.	Citizen of What Cou U.S.A.	ntry?						
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23e or 28s-f ehow enty injury or other treumatic event, the Medical Evanting must be notified at ODGs.	by Funera	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 1 2. Was Decedent Eve Armed Forces? 1 2 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh							
Baltimore, Maryland 21215-0036	id within 72 ho giene. er then "natu	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12	(Give	lent's Usual Occupa kind of work done of DO NOT use retired	turina most of work	ing	. Kind of Business/Ir Construction							
yland	ould be file Mental Hy arked oth	To Be (17. Father's Name (First, Middle, Last) Conrad H. Williams				e (First, Middle, Maid Mercer	len Sumame)							
, Mar	and 2 shoalth and 27 is mertreum		19a. Informant's Name/Relationship (Type, Print)	172/2001 (0	g Address (Street a Stoner Aveni		al Route Number, Cit inster Marv		o Code)						
imore	Pages 1: nent of He ant: If Iten ury or oth			20b. Place of Disposer Commetery, cremetery, cremetery.	sition (Name of		Date 20c.	Location - City or The Ison, Maryla							
- Balt	permit. Departimportimportimporti		21. Signature of Funeral Service Ligenses Nanles & Wisse &		Name and Address		5305 Harfo Baltimore,		21214						
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)		_	29b. Signature and title of certifier	no	05	778	7 Au	Date signed (Month,	9, 2007						
	lo		30 Name and address of person who completed cause of death	LOCH R	AVEN !	SLUD, T.	BALTIMI	ore m	0 21239						
3	Sta Registr	-	31. Date filed (Month, Day, Year) 32. Registrar's AUG 3 0 2007	Signature	artis										

		State of Maryland / Department of Health and Mer 1 - State of Maryland / Department of Department Certificate of Death	ntal Hygi	_	27884
Physici /Medi		an Marian Wassel	Date of Death Month	Day a Year	3. Time of Death
Examir Funeral Director		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimere Washington Medical Center 5. Social Security Number 6. Sex 7 7 Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 18	. Date of Birth (Month, Day 0 – 10 – 19	9 Birt	th AruafeV Inplace (State or Foreign NJ 10d. Inside City Limits
vith the Mary or 28a-f sh be notified	Funeral Director	MD Anne Arundel Crofton 10e. Street and Number 15.26 Moral because Country 2111/	100	g. Citizen of What Co	1 □ Yes 2 □XNo untry?
altimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	1536 Marlborough Court 21114 11. Marital Status 1	ry Yes or No- can, etc.)	USA 14. Race - Ame Black, White Specify:	
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permit. P. Departme Important any injury		121. Signature of Fune Rel Service Licensee M01364 22. Name and Address of Facility Sing: 1 2nd Ave SW Glen But	leton F rnie MD	uneral & (21061	
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Registi	ar	AUG 3 0 2007 Degree & Soule			

State of Maryland / Department of Health and Mental Hygien 2007 27885 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** ANNA MARIE 2007 X AMTMANN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner ROSEDALE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | MAY 14,1918 MANOR CARE ROSSVILLE BALTIMORE 5 Social Security Number 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 ☐ M 2 ☐ XF 89 Yrs. Director 224073633 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show 1 ☐ Yes 2 No Director MD BALTIMORE ROSEDALE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? or iteme 23a 2016 LONGVIEW CT. 21237 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: WHITE 3 X Widowed 4 ☐ Divorced the Medical Ext "naturel" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PAYROLL SECRETARY CLOTHING 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOSEPH P. WIEDORFER MARY YOUNGBAUER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth a important: if item 27 is any injury or other tra-2016 LONGVIEW CT BALTIMORE, MD 21237 MARGARET PITT SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State HOLY REDEEMER 8/27/07 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part1. The risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death A NUAN CED Immediate Cause (Final Physician GYLS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ò Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificete hes b irector, page 2 si 1 ☐ Yes 2 DNo Hospital or Attending Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ٩ 2 ER/Outpatient 3 DOA this After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Director: / 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funarai C
completely filled i 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only ÷ 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DUD ans MY AUGUST 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 an mos OSLEM PALVE TOWSON JUN 21204 7 565

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 3

1 2007

Baltimore,

1000000: P.O. Box 68760,

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2007 1 - For State Registral 27886 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 4:00 PM 28 soone 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examine Sinai Bultmore HOSPITA Wiltimore | Hunder 1 Vear | Hunder 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Days | Min. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | Oct. | O Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**№** M 2□ F Director ennsylvania death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show iral", or items 23a or 28a-f shore Examiner must be notified at 1 Yes 2 No by Funeral Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) any Injury or other traumatic event, the Medical and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) embluman حک senera 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Informant's Name/Relationship (Type. Print) (Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important; If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee M Ave. Balto. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Metastatic **Physician** YEUrs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reaumy to immediate cause. Enter Underlying Cause (Disease or injury Day to (or as a consequence of): Examine The iaw requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown signed by the detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an perform To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No 2 ER/Outpatient 3 DOA P 1 patient 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🗌 Yes 2 □ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, 2401 W. Belvedere Hospital MD Sinai More J050 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

Registrar

AUG 3 1 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 27887 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1000 PM Year **Physician** BOBLITS IRA EDWARD 08 0 29 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN Square BalTimoRe Center Ro Sedale HOSPITAL If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year 1-7-1936 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 **M** 2 □ F 71 MARYLAND Yrs. 213-32-6593 **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No BALTIMORE **ESSEX** Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1551 WILLIAMS AVENUE 21221 U.S.A. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1⊠Yes 2□No If Yes, Give Year or Dates: 1958–61 1 Never Married Married 1 ☐ Yes 2 ☐ No Specify Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) MOVING & STORAGE WAREHOUSE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN BOBLITS (UNKNOWN) UNKNOWN ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PEGGY BOBLITS/WIFE 1551 WILLIAMS AVENUE ESSEX, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State HOLLY HILL CEMETERY 9-1-07 4 ☐ Donation 5 ☐ Other (Specify) MIDDLE RIVER, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licenses ROSEDALE, 1211 CHESACO AVE 21237 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** DRUG ReSISTANT MULTI disease or condition resulting in death) Due to (or as a consequence of): Chronic TRachesTomy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner FaiLure COPD/ RESPIRATORY Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death 9□Unknown Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760, signed by the a

21215-0036

Maryland

Baltimore.

d 2 sho Id be filed vithin 7 th and Nental Hygiene. 7 is marked other than "

Pages 1 and 2 tment of Health 8

al or Attending Patter death.

I Director: After do in by the funera

4 ☐ Homicide

29b. Signature and title of certifier

and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

BALTIMORE

RES 00000

08-29-07

md

21237

M.D. 30. Name and address of person with completed cause of death (Item 23a) (Type, Print)

DRSHRIVATSA NadIGER 9000 FRANKLIN Square DRIVE

31. Date filed (Month, Day, Year) State AUG 3 1 2007 Registrar

29a. Certifier

(Check only one)

Medical

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene, 27888 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 200^{Year} Adelaide Clara Bechtler 5:30 A Aug. 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Renaissance Gardens at Charlestown Baltimore Catonsville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)

New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 20,1915 Director 050-07-3690 Jan. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at 10d. Inside City Limits 1 ☐Yes 2 No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or must be n # PV404 715 Maiden Choice Lane 21228 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items dical Examiner mu 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify ρ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own home marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental F Is marked of Pages 1 and 2 should be ၉ John Joseph Thomas Waldron Adelaide Clara Bruns 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of Item 27 Is Rosemarie Goodwin / Daughter 1733 Tarleton Way Crofton. MD. 21114 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ₽ permit. Pages
Department of
Important: If It
any injury or c 1 M Burial 2 □ Cremation 3 M Removal from State 4 □ Donation 5 □ Other (Specify) inden Hill Meth. Cem. 08/30/2007 Brooklyn, NY 21. Signature of Funeral Service Licens 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-tran The law requires that the death certificate be exect Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 □ Ectopic pregnancy for Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 ☐ No 1□ Yes 2 - No director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1. Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) POO 2040 house large s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add am my 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 27889 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Frederick J. Bakon 2007 4:43 P M August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 11X M 2□ F Hours 89 021-05-3133 Director Feb. 22. Massachusetts 1918 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notifled at Director Maryland Montgomery Chevy Chase 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8100 Connecticut Avenue, #1004 20815 United States Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 1X Yes 2 □ No If Yes, Give Year or Dates: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or Specify: White 1 ☐ Yes 2 🗓 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Engineering Draftsman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Health and Mental H Important: If item 27 is marked oil any Injury or other traumatic even once. Bakon Joseph Stefania Adamczyk 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8100 Connecticut Avenue, #1004, Chevy Chase, MD. 20814 Mercedes N. Bakon/ Wife 20b. Place of Disposition (Name of cemetery, cramatory or other place)
Gare of Heaven
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State tery 2007

22. Name and Address of Facility Robert A. Bethesda-Chevy Chase, Inc.

Maryland 20814 1 N Burial 2 □ Cremation 3 □ Removal from State Silver Spring, Maryland 4 Donation 5 Dother (Specify) Pumphrey Funeral Home/ . 7557 Wisconsin Avenue 21. Signature of Funeral Service Licensee ette Ought M01305 Bethesda, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Prostate Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause [Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and is the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Septicemia 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed Pneumonia 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an performed? Yes 2 No certificate 1□ Yes To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🛣 No 1 🕅 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death . Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 🕅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0064588 DU 0 1041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, Maryland Ashish Tolia MD Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician Adelaide Elaine Bowers 26, 2007 August 6:40 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Friends Nursing Home Montgomery Sandy Spring 8. Date of Birth (Month, Day, Year) Feb. 8, 1911 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2万F 96 577-52-9003 Director Washington, Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23s or 28a-f show injury or other traumatic event, it a Madical Exertirer must be notified at 1 Yes 2 No MA Norfolk Brookline Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17 Newell Road 02446 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: þ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Depurtment of Health and Mental Hygiene important: If item 27 is marked other than *r any injury or other traumatic auant Elementary/Secondary (0-12) College (1-4or 5+) Secretary Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Irving E. Griggs Altah L. Smith ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Joseph Bowers/Son 17 Newell Road, Brookline, MA 02446 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 20a. Method of Disposition 20c. Location - City or Town, State August 30, 1 Burial 2 □ Cremation 3 □ Removal from State 2007 Suitland, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of Funeral Service Licenses M01346 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician KESPIRATORY ACUTE 2 HOURS /Medical Due to (or as a consequence of): Examiner SURFERS SPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner MAWY certificate be executed as the burial-transit MYSCHIC Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical Crmonda 61313 use. 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy signed by the atte in the past 12 months? Dav Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown 5100 86120515 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an MILLO DEMEMLING autopsy performed 2□ No 2 No 1 TYes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartified Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 No 2 4₹ Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 25345 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SILVER SPRING 0. 1731 Balses CHANGY WD E. GLBHO 777 31. Date filed (Month, Day, Year)
AUG 3 32. Registrar's Signature State Registrar

		For State Registrar	State of M	laryland /		rtment			nd M	, ,	-	007	2789	
Physicia /Medic	_		Leroy B	eckhardt	t					2. Date of Dea Month AUGUS	Day	Year 2 212	7 07:01P	
Examine	er	4a. Facility Name (If not institution Saint Josep	n, give street and number oh Medical	Cente	r	4b. City, 7	Fown, or	Location of C	f Death 3 W S O	4c. County of Do			eath ltimore	
Funeral Director		5. Social Security Number 212-36-4034 Usual Residence of Decedent	6. Sex 1 M 2 □ F	ge (In yrs. last bi	irthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day Nov 7,	^h 1938	9. Bi <i>C</i> Ma	rthplace (State or Fore country) aryland	ign
Maryland a-f show ified at	ctor	10a. State 10b. County	timore	10c. City, Tov	vn or Loc								10d. Inside City Limi	
with the 3a or 28 st be not	I Dire	10e. Street and Number 233 East Timon	ium Rd.			10f. Zip	Code 21 D	93				n of What C	ountry?	
al", o	by Funeral Director	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Deceden Armed Forces ied 17 Yes 2 If Yes, Give Year or Dates	? ! No 61 - 62		Vas Deced Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)		. Race - Am Black, Wh	erican Indian, ite, etc. White	
within 72 ho ene. Ihan "natu ne Medical	Be Completed	15. Deceden (Specify only highest Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4or 5+	.54)	(Give I life. D	ent's Usua kind of wor OO NOT us trica	k done di e retired)	uring most		g		of Busines:	s/Industry Decker	
uld be filed v dental Hygie rked other i tic event, th	To Be Co	17. Father's Name (<i>First, Middle,</i> Simon Be	Last)	Beckhard		<u> </u>		18. Mother		(First, Middle,		ırname)	Stinchcomb	
und 2 sho alth and N 27 is ma or trauma		19a. Informant's Name/Relationsl				-				Route Numbe		own, State, 21 05		
Pages 1 a lent of He. nt; If item ry or othe		20a. Method of Disposition 1		20b. Place of cemeter Ramse	of Dispos ery, crem By Ce	ition (Nam natory or ot emete:	e of ther place	e)	9/5/	ate 07		-	r Town, State .linois	
permit. Departrimental		21. Signature of Funeral Service		m G. Dau						k Towsc son, MD			Hoem, Inc.	
Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each	ed the death. Do line.	not ente	er the mode	of dying		-				Approximate Interval Between Onset and Death	
/Medical Examiner		resulting in death)		s a consequence		DER	CAN	CER						
ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	s a consequence s a consequence							_			
ficate be physicia ts the bur	ical		d											
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e pf pregnancy 2 □ Fetal deat at time of death		Ectopic pre Other (spe					236	d. Date of d Month	elivery Day Year	
quires that en signed by uld be deta	2	Part II. Other significant condition CHRONIC OBSTRU	-				use give	n in Part I.		23e. Did to			to the cause of death? Probably 4 □Unknow	
Physician: The law re rithis certificate has bee rail director, page 2 sho	Completed											24b. Were a prior to death? 1 □ Ye		ble of
ysician is certifii director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	tient 2 ☐ ER/O	utpatient	: 3□ DO	A Othe	r.		(Check only on		Other (Sp	ecify)	
ath. r: After thi	ation: T	27. Manner of Death 1	g 28a. Date of In (Month, E		Time of Injury	M 2	Bc. Injury Work		2	8d. Describe h				
To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	inod Zoe, Place of I	njury - At home, f etc. (Specify)	arm, stre	et, factory	, office		2	8f. Location (S City or Tow	Street and I In, State)	Number or I	Rural Route Number,	
ne Hospi n 24 hour ne Funer pletely fill	Medical		g Physician: To the bes Examiner: On the basis and manners	of examination a										
To the within to the complex c	Ž	29b. Signature and title of certified	4 EU1	/			License			2	29d. Date	signed (Mor	nth, Day, Year)	
10 X1		30. Name and address of person JAMES EBELIN				Print)	UE"	TOLL	ISON.	, MARY	I ONE	20.1	2014	
Stat Registra	e	31. Date filed (Month, Day, Year)	3 1 2007	trar's Signature	A.	Apa	L'S	1 (394	المات	i intervi	IN PHYSIC	lum de	less Ves Ves	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27892 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 8:20P.M /Medical 200 4a. Facility Name (If not institution give street and number) 4b. City, Town, or Location of Death Examiner County of Death Harford Running Hil If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year)

Ped 21, 1928 Baltimore MD 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F AIA A4 9730 Usual Residence of Decedent Director 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sh edical Examiner must be notified 1 ☐ Yes 2 No Completed by Funeral Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with Innet of Health and Mental Hygiene.

ant: If item 27 Is marked other than "natural", or items 23a or: USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced White er than "natura , the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) nonemaker home 7 Is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be homa ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health Important: If item 27 any Injury or other ti FRANCI. ochran 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Long Green & 3107 Hu 22. Name and Address of Facility 3 Newport De 4 ☐ Donation 5 ☐ Other (Specify) Enn's Long Greenlem 21. Signature of Funeral Service Licensee FORS HILL 23a. Part1. Enter the dise se, or or my lications that valued the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List my one cause on a h line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** noma mon /Medical Due to (or as consequence of): Examiner 400cs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 🔣 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 No Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 2No ဥ 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D15546 Charles (ball to us) 28.2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles adgett 5601 Loch Baven Bluze, Dattimore, No 2239 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State of Maryland / Department / Department / Depa	artment of Health and Martificate of Death		ne 2007 27893
·	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
and the second	/Medi	cal	Jeannette M. Cullen		August	28, 2007 4:15 A M
	Examir	ner		4b. City, Town, or Location of Death		4c. County of Death
	Funeral	1	13321 Fork Road 5. Social Security Number 26. Sex 7. Age (In yrs. last birthday)	Baltimore If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Baltimore
	Director	į.	2\3-60-6733 10M 2\F 56 Yrs.	Months Days Hours Min.	Jan. 7, 1	
	pug		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lot		Jan. 7, 1	
	faryla shoved ed at	ō	111111111111111111111111111111111111111			10d. Inside City Limits 1 ☐ Yes 2X No
	the N 28a-i	Director	Maryland Baltimore B.	altimore 10f. Zip Code	100	Citizen of What Country?
	h with	i D	13321 Fork Road	21013	Tog.	·
	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Vas Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	U. S. A. 14. Race - American Indian,
36	s after , or its	y Fu	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give	Yes 2 No Specify:	rican, etc.)	Black, White, etc.
21215-0036	hours tural" al Exa	ed by	3 Wildowed 4 Divorced Year or Dates:			Specify: White
5	iin 72 n "na Medic	Completed	(Specify only highest grade completed) (Specify only highest grade completed) (Give I life. D	ent's Usual Occupation kind of work done during most of worki DO NOT use retired)	ing 160	b. Kind of Business/Industry
212	d with giene er tha	mo	Elementary/Secondary (0-12) College (1-4or 5+)	Clerk		State of Maryland
nd	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f show atte event, the Medical Examiner must be notified at	Be		18. Mother's Name	(First, Middle, Maid	
Maryland	should the marked umarked	2	Lawrence Gill		alee Jone	
Mai	0, 00 0			g Address (Street and Number or Rura		
	is 1 and 2 of Health item 27 i		20a. Method of Disposition 20b. Place of Dispos	Fork Road, Baldw		and 21013 Location - City or Town, State
altimore,	0 0		1 🔀 Burial 2 □ Cremation 3 □ Removal from State Dulaney 4 □ Donation 5 □ Other (Specify)	valley		
alti	permit. Pag Department Important: I any injury o once.		Meliorial	Name and Address of Facility Sch	/200/ T1: imunek Fu	monium, Maryland
m	e a ii ii ii		Buin a. Wellen 97	05 Belair Road, No	ottingham	, Maryland 21236
	4		23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.	r the mode of dying, such as cardiac o	or respiratory arrest,	Approximate Interval Between
W.	Physician		Immediate Cause (Final disease or condition resulting in death)			FIVE YEARS
	/Medical Examiner		Due to (or as a consequence of):			
		ıer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause threads of injury.			
	cuted nd ransit	Examine	triat mitiated events			
Š,	cate be executed bhysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):			
09/80	ficate be executed physician and s the burial-transit	dical	d			
×	requires that the death certific een signed by the attending p nould be detached for use as	Physician/Me	IF FEMALE: 23b Was decedent progner; 23c. If yes, outcome pf pregnancy			
ROX	death atter	iciar	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
J.	w requires that the debeen signed by the should be detached	hysi	9 ☐ Unknown			
້ ທົ	es tha gned be del	by P	Part II. Other significant conditions contributing to death but not resulting in the und	derlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
Hecords,	een si				1 ☐ Yes	2 No 3 Probably 4 Unknown
ပ္ပ	aw Is b	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
	ate ⊐				performed	? death?
VITal	Physician: this certific	Be	25. Was case referred to medical examiner? 1 Yes	26. Place of Death		
o	J Physer this eral di	<u>ا</u> ي	27. Manner of Death 28a. Date of Injury 28b. Time of	3 BOA 4 Nursing Hom	ne 5 Residence 28d. Describe how in	6 Other (Specify)
0	ath. r: Afte e fun	atio	1 SNatural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		, any occurred
DIVISION	r Atte er deg recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)	et, factory, office 2	8f. Location (Street City or Town, St	and Number or Rural Route Number,
5	ital o	Ce				,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier Certifying Physician: To the best of my knowledge, death (Check only one) Medical Examiner: On the basis of examination and/or invegence of the control of t	occurred at the time, date and place, a estigation, in my opinion, death occurre	and due to the cause ed at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	o the	Med	and manner stated. 29b. Signature apd title of certifier	29c. License number		Date signed (Month, Day, Year)
	- s - ō		· CM 3	D0056296		-28-2007
,	19	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Pr		, 4	
-	1		Dr. Jason Birnbaum, 520 Upper Chesape	ake Drive, Bel Ai	r, Maryla	nd 21014
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 3 1 2007	Cart .		
	negistra		MOUSI LOUIS TARREST AS A			

Registrar DHMH 17 Rev 1/2001 OCME 2006

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 3

Theodore M. King, Jr., MD.

Registrar's Signature ORIGINAL

Assistant Medical Examiner

29c. License number

O.C.M.F.

111 Penn Street, Baltimore, MD 21201

OCME

29d. Date signed (Month, Day, Year)

August 29, 2007

07-06547 Jenate Carroll

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	4	U	U	- [4	-	U	9	4

r		1- For State Registrar		Certif	icate of	Death			Reg. No	200	1 2109
Physici Medical Exami		Decedent's Name (First, Mid-						2. Date of I Month	Death Day	Year	3. Time of Death 0107 hrs
Mepical Exami	Hei	Je Nate Francisca 4a. Facility Name (if not instituti	on, give street and number)		Ι 4	b. City, Town, c	r Location of	Month August		c. County of Death	01071115
		Good Samaritan Hos				Baltimore	n Loodiion of	Death		c. County of Dodin	
Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last	birthday)	If Under 1 Ye		r 24Hrs. 8. Date o	Birth(MM	1/DD/YYYY) 9. Birth	
Director	1	L55 - 84-8906	1 M 2 X F	30	Yrs.	Months Da	ys Hours	Min. 2-7-19	977	Foreigr Cou	ntry) NJ
*****************		Usual Residence of Decedent		140- Oil T-		· · · · · · · · · · · · · · · · · · ·			71.11		
ow any		10a. State 10b. County	,	10c. City, To		n					10d. Inside City Limits 1 Yes 2 No
Aaryland 28a-f show I at once.	. ig	MD r	ı∕a	Balti	more	10f. Zip Code			I 10a Cit	tizen of What Coun	21
ith the Maryland 23a or 28a-f sho notified at once.	Director	1548 E. Coldsprir	no Tame			2121	18		log. Ci	USA	uy:
with the rs 23a se noti		11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was			in? (Specify Yes or	No- '	14. Race - Americ	an Indian, Black,
death or iten	uneral	1 X Never Married 2	Married Armed Forces?	X No	lf Y∈	s, specify Cuba	an, Mexican,	Puerto Rican, etc.)		White, etc.	an-American
after	by F		vorced If Yes, Give Year or Dates:			Yes 2 X N				Specify:	
hours "natu Exan	ted	 Decedent's Education (Sp Elementary/Secondary (0-12 				's Usual Occup st of working lif		ind of work done use retired)	16b.	Kind of Business/Ir	ndustry
36 thin 72 e. than	ple.	11th	College (1-4 of		htrepre	neur			Se	elf-Employee	1
215-0036 be filed within 72 hours sal ntal Hygiene. ked other than "natural ent, the Medical Examin	Completed	17. Father's Name (First, Middle	e, Last)				18.Mother's	s Name (First, Midd	le, Maider	n Surname)	
2121; uld be fill Mental F marked	Be	Nathan F.V. Carrol						M. McPhers			
O å ₽ % 📜	12	19a. Informant's Name/Relation	. , , , , ,							City or Town, State,	Zip Code)
Baltimore, ME permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum	- 1	Carletta I. MrKnig 20a. Method of Disposition	ht/Cousin			tion (Name of c		, Baltimore		Location - City or 1	Town State
iges 1 it of H			n 3 Removal from St	ate crer	natory or oth	er place)	,,,	8-29-07			
Baltimore, permit: Pages I an Department of Hea Important: If iter injury or other tr	-	4 Donation 5 Other S		Meuro	Cremat		ss of Facility			altimore, Ma mc P.A. of	
De De De De De De De De De De De De De D	1	Tandow	M. Wille	,)				Randallstow			Internation County
Physician	1	23a. Part I. Enter the disease, of failure. List only one caus		the death. Do	not enter th	e mode of dying	g, such as ca	ardiac or respiratory	arrest, sh	nock, or heart	Approximate Interval Between Onset and
/Medical xaminer	1	Immediate Cause (Final diseas	e a. Alcohol an		lone int	oxicatio	n			8	Death
		or condition resulting in death)	Due to (or as a conse	equence of):							
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10	Examine	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons	equence of):						_	
outed of the state		events resoluting in death) Last	d	- 4							
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68760, certificate be a nding physicia		IF FEMALE: 23b. Was decedent pregnant in	23c. If yes, outcor	ne of pregnan	су				23	3d. Date of delivery	
Sox 687 leath certifit e attending for use as t	cian	past 12 months?	I Live Ditti	time of death		al death 3 er (Specify)	Ectopic	pregnancy		Month D	ay Year
Box e death ce the attened for us	Physician	1 Yes 2 No 9 V	nknown g Unknown		o our	er (apoony)		800			
that the d	by P	Part II. Other significant cond	itions contributing to death	h but not resul	Iting in the ur	nderlying cause	given in Par		_	use contribute to t	
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tal Rec ian: The l certificate l	Completed							1 🗸 Ý	es 2 I		s 2 No
of Vital Records, P.O. ng Physician: The law requires that if ther this certificate has been signed by meral director, page 2 should be detact	a	25. Was case referred to medic examiner?	Hospital:	ent 2 🗸 ER	NOvitantiant		Other	Check only one)	Desid	lence 6 Other:	
n of Viding Physi	۲.	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Inju	ıry 28	b. Time of In		ury at Work?	Nursing Home 5 28d. Descr		lence 6 Other:	
Sion (Mtending death. ctor: Ai	힐		Month, Day, Y Inding Fnd 8/24/		nd 12:30) am 1	Yes 2X	No unk			
Division spital or Attendin ours after death.	ië	2 Accident Inversion 3 Suicide 6 X Cou	290 Diogo of in				building, etc				al Route Number, City
Divis	Certification:	4 Homicide det	and a second	residence	е			1548 C	ldspr	ing Lane Ba	ltimore, MD
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		,	hysician: To the best of mainer:On the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of the basi	-							
To t To t	Medical	29b. Signature and title of certif	and manner stated.				se number			. Date signed (Mon	
		('a) 10	La or	000			.M.E.			gust 24, 2007	,/
A	}	30. Name and address of perso	n who completed cause of d	eath (Item 23:	a)						
5			ssistant Medical Exar		1 Penn S	treet, Baltin	nore, MD	21201			
	ate	31. Date filed (Mooth, Pay, Year AUG 3 1	2007 32. egistra	r's Signature	1	E)					
Regist	للغاد	U	7001		1						

			Flease		ack indelible ink. Ensure	•	•	
			1 = For State Registrar	State of Maryland	/ Department of Health and Certificate of Death		2007	27896
			Decedent's Name (First, Middle, La	St)	Continuate of Beating	2. Date of Death		3. Time of Death
	Physic /Medi		Glennie	Carter		Aug, 2	8,2007	9:15 M
	Exami	ner	4a. Fecility Name (If not institution, giv	street and number)	4b. City, Town, or Location of Dec	ath J	4c. County of Death	
	Funeral		5. Social Security Number 6. S			s. 8. Date of Birth	9. Birthr	place (State or Foreign
	Director		000-0100	□M 200 F 7/	Yrs. Months Days Hours Mi	March 9	1936 NOT	The Caroline
	yland now		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Location		1	10d. Inside City Limits
	e Man la-1 sh	ctor	Md. Hou	ard (olumbia			1 XYes 2 No
	death with the Maryland ms 23e or 28a-f show f must be rediffed at	Dire	10e. Street and Number	Call AL	10f. Zip Code	10g.	Citizen of What Cour	ntry?
	death ms 23	eral	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin?	Specify Yes or No-	14. Race - Americ	can Indian
9	after or Ite	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give	if Yes, specify Cuban, Mexican, Pue	nto Rican, etc.)	Black, White,	
21215-0036	hours after turel', or Ite	Completed by Funeral Director	3 Widowed 4 □ Divorced	Year or Dates:			Specify: Bl	ack
215	within 72 ene. than "nat	plete	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed)	 Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired) 	orking 16b	. Kind of Business/In	dustry
	filed with Hygiene. other than	Com		College (1-4or 5+)	Homemaker		Hom	e
and	ould be fil Mental H arked oth atic even	Be	17. Father's Name (First, Middle, Last)	Pala	18. Mother's Na	ame (First, Middle, Maid	len Sumame)	
Maryland	2 should and Men Is marke aumatic	ဥ	19a. Informant's Name/Relationship (Type, Print) aug. te	9b. Mailing Address (Street and Number or F	Rural Route Number, Cit	ty or Town, State, Zic	Code)
_	1 and 2 Health a tem 27 Is		Mrs. Mary Cart	er Byrd !	5408 Bucksaw	Ct. Col	imbia.	VA. 21044
Jore	ages 1 of of H : If itel		20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☑	Removal from State	of Disposition (Name of etery, crematory or other place)	Date 20c	. Location - City - To	own, State
Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23e or 28a-f show any niury or other traumatic event, Ite Medical Evantinat must be notified at our.	l e	4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer	T (WIII	PTON VITGINIA CEM. 22. Name and Address of Facility	1/200/ NO	wport 1	veus, va.
8	D p m		Menh	L. Buss	Joseph L. Russ	Funeral, H	one P.A.	16
			23a. Parti. Enter the disease, or com- shock, or heart failure. List only	incations that caused the death. E	o not enter the mode of dying, such as cardia	ac or respiratory arrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Metastati	c Adono Cancinom	A Live	l	Onset and Death
	Examiner			Due to (or as a consequent	of unknow	WW MAT	maru :	2 months
	p ji	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence)	
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequence	ce of):			
260	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cal	l	d				
89)	death certificate b attending physic d for use as the b	Physician/Medl	IF FEMALE:					
Вох	attend for use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death			23d. Date of delive Month	ery Day Year
P.O.	that the di ed by the detached	hysic	1 Yes 2 No 9 Unknown	9□ Unknown	5 Other (specify)			
	res tha signed I be det		Part II Dther significent conditions of	ontribuung to del th but not resulting	g in the unterlying cause given in Part I.	23e. Did tobacc	o use contribute to th	ne cause of death?
ord	w require been sig should b	eted	Divinous 6	on he	MUSI ILI	1 🗆 Yes	2DNo 3□Prob	ably 4 □Unknown
Vital Records,	: The law cate has b	Completed by	THE MANY CA	IDUIUS		24a. Was an autopsy performed	prior to cor	psy findings available mpletion of cause of
ital		a)	25. Was case referred to medical		26. Place of De	1 ☐ Yes 2 ☐	No 1 ☐ Yes	2 No
of V	Physic this ce al direc	To B	1 193 57110		Outpatient 3 DOA Other: 4 Nursing	\ /	6 □Other (Specify	1)
ouo		tlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b	D. Time of 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how in	jury occurred	
Division	Attendi er death. ector: A by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home,		28f. Location (Street	and Number or Rura	l Route Number,
ā	itel or A		Tiomedy	building, etc. (Specify)		City or Town, Sta		
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exem	sicien: To the best of my knowled iner: On the basis of examination and manner stated.	ige, death occurred at the time, date and plac and/or investigation, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as stand due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of dertifier	A A	29c. License number	29d. [Date signed (Month,	bay, Year)
			· /aum J	Summer	DO 05/4	73 1	130/1	17
			30. Name and address of person who	empleted cause of death (Item 23a	(Type, Print)	CI I	K than h	ASh.OC
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1000	MM Of N	L FUXI &	(001)
	Registr		AUG 9 1 2007	Alexander Alexander	hood to			

07-06616

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

imothy Carter		State - For State Legistrar	te of Maryland /	Depart <i>Certi</i> i	ment of I ficate of L	Health and Death	Mental I		g. No. 26	07 2789
Physician	1	 Decedent's Name (First, Middle, 	_ast)					Date of Death Month	Day Year	3. Time of Death 1206 hrs
Medical Examine	ш.	Timothy		Car	ter	. City, Town, or L	eastion of Do	August 26,	4c. County of De	
	1	4a. Facility Name (if not institution, Mercy Hospital	give street and number)			Baltimore Cit	ty	4		
Funeral Director		215–94–9315	. Sex 7. Age	(In yrs. last	birthday) 27 Yrs.	If Under 1 Year Months Days	If Under 24H Hours M	lin.	l Fo	Birthplace (State or or or or or or or or or or or or or
any and any and any		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, To	own or Location	า	<u> </u>			10d. Inside City Limits
<u> </u>	ای	Maryland Harfor	rd	А	berdeer	า		1		1 Yes 2 X No
the Maryland or 28a-f show iffed at once.	3	10e. Street and Number				10f. Zip Code		10	g. Citizen of What (Country?
ith the Maryland 23a or 28a-f sho notified at once		214 Baltimore St	reet			21001			USA	
after death with the Maryland al., or items 23a or 28a-f sho iner must be notified at once.	runerai	11. Marital Status 1 X Never Married 2 Mar		ver in U.S. X No		Decedent of Hisp s, specify Cuban,		Specify Yes or No- rto Rican, etc.)	14. Race - A White, et	merican Indian, Black, tc.
after o	Š.		ced If Yes, Give Year or Dates:			res 2X No			Specify: W	
hours		15. Decedent's Education (Specif	, , , ,			s Usual Occupations of working life.			16b. Kind of Busine	ess/industry
AD 21215-0036 2 should be filed within 72 hours. hand Mornell Hygiene. 27 is marked other than "natur mustic efent, the Medical Example. The Computed of the manual than the Medical Example.	Completed	Elementary/Secondary (0-12) 12 year	College (1-4 or 5	-)	Machir					aste Renoval
15-0 illed w Hygic d othe		17. Father's Name (First, Middle, L						me (First, Middle, M	Maiden Surname)	
127 Id be f Aental	- 1	Richard C. Carte 19a. Informant's Name/Relationshi	rear and the second		19b. Mailing			G. MOWers or Rural Route Num	nber, City or Town, S	State, Zip Code)
MD 2 should and N m 27 is n aumatic	1	Richard C. Carte		er					en, Maryl	and 21001
- p = e =		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from Sta		ace of Disposit	ion (Name of cemer place)	netery, S	Date eptember	20c. Location - Cit	ty or Town, State
Baltimore, permit. Pages I an Department of Hee Important: If ite Important: If ite Impury or other tr	-	4 Donation 5 Other Spe 2 Signature of Funeral Service L	cify:		_			1, 2007		River, MD.
Baltir permit. I Departme Importa	Į	2) Signature of Furieral Service L	Ann di O	000	Cor	nelly Fu	uneral	Home Of	Dundalk,P Dundalk,	A. MD 21222
Physician	4	23a. Part I. Enter the disease, or c	omplications that caused	he death	o not enter the	e mode of dying,	such as cardia	ac or respiratory arr	est, shock, or heart	Approximate interval Between Onset and
'Medical		failure. List only one cause o	a. Hanging)		•			Death
aminer	1	or condition resulting in death)	Due to (or as a conse	quence of):						
	<u>آ</u> و	Sequentially list conditions, if any, leading to immediate	b Due to (or as a conse	quence of):						
d d	Examiner	cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):	<u> </u>	_				
6 be executed ssician and burial - transit	edical E	Xunpended	d.					<u>. </u>		
30, te be el ysiciai	ğ		4#232,27,28 23c. If yes, outcom			3, 11/21/0	7 TT		23d. Date of de	elivery
Box 68760, e death certificate be the attending physic ed for use as the bur	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fet	al death 3	Ectopic pre	egnancy	Month	Day Year
OX 6 ath ce	SIC	1 Yes 2 No 9 Unkr	Pregnant at nown g Unknown	time of dea	th 5 Oth	er (Specify)				
the de ched f	Phy	Part II. Other significant condition		but not res	sulting in the u	nderlying cause g	iven in Part I.	23e. Did t	obacco use contribu	ite to the cause of death?
P.C es that	히						-	1 Ye	s 2 No 3	Probably 4 🗸 Unknown
rds, requir	Completed	·			-			24a. Was		ere autopsy findings available or to completion of cause of
eco ne law te has ge 2 s	틹								ormed? dea	ath? ✓ Yes 2 No
II R	ညို ရှိ	25. Was case referred to medical	1				of Death (Ch			
Vits of I direc		examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	nt 2 🗸 I	ER/Outpatient			ursing Home 5		Other:
ing Pi		27. Manner of Death	28a. Date of Inju (Month, Day,Y	ry ear)	28b. Time of Ir		ry at Work?		how injury occurred	
sion ttendideath.	훓	1 Natural 5 Pendi 2 Accident Invest	ination Tike 0/ 20) am	Yes 2 X No	Subject	hanged self	or Rural Route Number, City
Division of Vital Records, P.O. ital or Attending Physician: The law requires that the urs after death. The law certificate has been signed by the funeral director, After this certificate has been signed by the funeral director, page 2 should be deasched in by the funeral director, page 2 should be deasched.	Certification:		not be Cel	1 of C	me, farm, stree entral Bo onal Faci	t, factory, office b coking and ility	State	or Town, Baltimor	State)	or Rural Route Number, City
	Medical C	29a. Certifier 1 Certifying Phone) 2 Medical Exam	ysician: To the best of miner:On the basis of exam	v knowleda	e. death occur	red at the time, da	ate and place, n, death occur	and due to the cau	se(s) and manner a and place, and due	s stated. e to the cause(s)
To with To con	ĕ	29b. Signature and title of certifier	and manner stated.			29c. Licens	e number	· · · · · · · · · · · · · · · · · · ·	29d. Date signed	(Month, Day, Year)
		Thurdy M	K. X.	4.0	40	0.C.	M.E.		August 27, 2	<u>2</u> 007
07		36. Name and address of person Theodore M. King, Jr.,		eath (Item edical E		111 Penn St	reet, Baltir	nore, MD 2120	1	
Sta		31. Date filed (Month, Day, Year)		r's Signatu	e .	- 44				
Registr		AUG 3 1	2007 Jan	- A	Sol	Can B				
DHMH 17 Rev 1/200	01				ORIGINA	L				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27898 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year 0447 M Ruth Candler Cagle RUOS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Nanyland Med. Ctr 6. Sex 7. Age (In yrs. las Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Yea May 18, 1 9. Birthplace (State or Foreign Country) North Carolina 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 88 1919 Director 237-12-1354 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Tayes 2 □ No Director MD Prince George's Bowie 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 3909 New Haven Ct. 20716 # B-2 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatine and the status. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Candler ပ Anna L Freedman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bowie, Diana Livingston / daughter 12802 Beechtree Lane MD. 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Macremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 8/29/2007 Alexandria, VA. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD. 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Edateral subdival hematomas,intraparenchima /Medical Due to (or as a consequence of): JUNE THERE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed for use as the burial-tran and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 🗆 Natural 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☑ No 2 Accident 12:00PM 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Home within 24 hours a To the Funeral I 13509 New Haven Ct. Bowie, MD 1 | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated

State Registrar 29b. Signature and title of dertifie

Osborn

Year)

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Greene

32. Registrar's Signature

29c. License number

Baltmare,

			For State Registrar	State of	f Marylan		artment of F			ental Hy	giene	007	27899
1	Physici		1. Decedent's Name (First, Middle, Carol H. Crim	Last)					- T	2. Date of Dea Month August	ath Day	Vear	3. Time of Death 5:47 P M
	/Medio Examin		4a. Facility Name (If not institution, g		mber)		4b. City, Town, o	lle		nugust	4c. Co	ounty of Death	
14-	Funeral Director		5. Social Security Number 6 214-42-3446 Usual Residence of Decedent	. Sex 1 □ M 2 X F	7. Age (In yrs. I 62	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	B. Date of Birt (Month, Day Nov. 3,	v, Year)	Coui	place (State or Foreign ntry) achusetts
	ne Maryland 8a-f show otified at	Director	10a. State 10b. County Maryland Montgo	omery		, Town or Lo	Le						0d. Inside City Limits 1 X Yes 2 □ No
	with the a or 2 the no		10e. Street and Number	٠. ا			10f. Zip Code				_	n of What Cour	•
036	be filed within 72 hours after death with the Maryland ntal Hygiene. At other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	5913 Halpine Roa 11. Marital Status 1 □ Never Married 2 🌣 Married 3 □ Widowed 4 □ Divorced	12. Was Dece	2 🕅 No		20851 Was Decedent of H f Yes, specify Cub I□Yes 2☑No	lispanic Ori an, Mexicar	igin? (Spec n, Puerto R		. 14	ed State Race - Americ Black, White, pecify: Wh	can Indian,
Baltimore, Maryland 21215-0036	d within 72 ho giene. r than "natur the Medical."	Completed	15. Decedent's (Specify only highest (Specify only highest (12)) Elementary/Secondary (0-12)	Education grade completed) College (1	-4or 5+)	(Give life, L Specia	lent's Usual Occup kind of work done DO NOT use retire al Assist Commissio	during most d) ant o				of Business/In	·
yland	es 1 and 2 should be filed of Health and Mental Hyg of Hem 27 is marked othe r other traumatic event,	To Be C	17. Father's Name (First, Middle, La Horace C. Hump	,				18. Mothe	M. V				
Mar	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship James H. Crim/Hu	, , ,		1	g Address (Street						
more,	Pages 1 and nent of Health int: If Item 27 iry or other to		20a. Method of Disposition 1	☐Removal from S	State	ace of Dispos emetery, cren	B Halpine sition (Name of natory or other place leaven Cer	ce)	Augus	te 31,	20c. Local	tion - City or To	
Baltii	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lic		- M011	Ro	Name and Address bert A. Pu O W. Monts	ss of Facility	y Funer	al Home	, Rock	ville, I	ng, Maryland nc. I 20850
	Physician / Medical Examiner the prival the	dical Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate any leading to immediate cause (Disease or injury that initiated events resulting in death) Last	a. Met Due to (d)		Breas ence of): ence of):	er the mode of dyir		cardiac or	respiratory an	rest,		Approximate Interval Between Onset and Death
O. BOX 68	eath certifi attending p for use as	Physician/Med	IF FEMALE; 23b. Was decedent pregnant in the past 12 months? 1 ∐ Yes 2 \notin No 9 ∐ Unknown	1 ☐ Live bi	come pf pregnar irth 2 □ Fetal ant at time of de wn	death 3	Ectopic pregnancy Other (specify)	/			230	d. Date of deliver	ery Day Year
rds, P.	w requires that the d been signed by the should be detached	þ	Part II. Other significant conditions	contributing to de	ath but not resul	ting in the un	derlying cause giv	en in Part I.		_			ne cause of death?
ř	> 0 0	Completed								24a. Was a autops perfor 1 Yes	med?	24b. Were auto prior to cor death? 1 □ Yes	psy findings available npletion of cause of 2 _ No
vital	ysiciar is certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	npatient 2 □ E	R/Outpatient	3 DOA Oth	or.		Check only or		☐Other (Specify	4
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 ompletely filled in by the funeral director, page 2.	Certification: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28a. Date o (Month) on be 28e. Place	of Injury h, Day Year)	28b. Time of Injury	28c. Injur Worl		28 No	d. Describe h	ow injury o	ccurred	l Route Number,
2	To the Hospital of within 24 hours at To the Funeral Completely filled in	Medical Ce	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex-	Physician: To the aminer: On the ba	isis of examinati	rledge, death on and/or inv	occurred at the tir	ne, date and	d place, an	d due to the o	ause(s) an	id manner as st	ated. the cause(s)
	To the within To the Comple	Me	29b. Signature and title of contifier	and mann	er stated.		29c. License	e number		2	9d. Date s	igned (Month,	Day, Year)
)			17 (m	33.			D0018	320			Augu	st 29,	2007
	15		30. Name and address of person who John Fetting, M.		·		Print) 1100, Ba	1timo:	re M	arvlan	d 21	231	
15	Stat Registra		31. Date filed (Month, Day, Year) AUG 3	1 2007	egistrar's Signatu	ire	John Da	L CLIIIO.	- C 9 I'I	ary rail	u 21	<u> </u>	

			1- State of Maryland / Dep. Registrar Ce	artment of Health and Mental	Hygiene 2007	27900
			Decedent's Name (First, Middle, Last)	2. Date	of Death	3. Time of Death
	Physici /Medio		Yu Gwan Chan a.k.a. Yu Chan a.k.a. Ge	orge Chan Augu	th Day Year	2:15 P.M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	
			Holy Cross Hospital	Silver Spring	Montgomery	
1	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8. Date Months Days Hours Min. (Mon	in. Dav. Year) Country	ce (State or Foreign
1	Director		213-04-9388 TSUM PLIF 84 Yrs.	Octob	er 30, 1922 Burma	,
	land ow		10a. State 10b. County 10c. City, Town or Lo	ecation	10d	. Inside City Limits
	Mary -f sh	ţo	Maryland Montgomery Rockville			1 ਊYes 2 □ No
	r 28a notif	irec	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country	?
	h with	Funeral Director	1405 Templeton Place	20852	United States	
	deat	ner		Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et	or No- 14. Race - American	
ဖွ	after or ite		1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No	in res, specify Cuban, Mexican, Pueno Hican, et 1 □ Yes 2 ☑ No Specify:		·.
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show iteal Examiner must be notified at	Completed by	3 Wildowed 4 Divorced Year or Dates:		Specify: Asia	n
15	"nat	lete	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Indus	stry
12	withi iene. than the M	duc	Elementary/Secondary (0-12) College (1-4or 5+) Merch	-	Town a safe / Essen a safe	
q	filed Hygi other ent, t	CC	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, N	Import/Export Middle, Maiden Surname)	S
Maryland	ld be lental ked c	To Be	H.Y. Chan	Aw May	·, ·····-,	
ary	shou and N s mar	_	19a. Informant's Name/Relationship (Type. Print) 19b. Mailin	ng Address (Street and Number or Rural Route I	Number, City or Town, State, Zip Co	
Σ	ss 1 and 2. of Health a item 27 Is.		Edward Chan / Son 1405	Templeton Place, Rockv	ille, MD 20852	
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, creation compared to the compa	sition (Name of natory or other place) August 30	20c. Location - City or Town	ı, State
altimore,	Pag ment ant: I			rematorium, Inc. 2007	Bethesda, Mary	yland
Ball	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Servic Licensee	Name and Address of Facility bert A. Pumphrey Funeral Ho	me/Rockville, Trc.	
	00 = 60	7	M00090 30	U W. Montgomery Ave.,	Rockville, MD 2	0850
	*		23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or hear failure. List only one cause on each line.	er the mode of dying, such as cardiac or respirat	In	pproximate iterval Between inset and Death
	Physician /Medical		Immediate Cause (Find disease or condition resulting in death) Pulmonary Edema			riset and Deam
B	Examiner		Due to (or as a consequence of):			
		ē	Sequentially list conditions, if any leading to immediate b. Atrial Fibrillati Due to [or as a consequence of]:	on		
3	uted d ansit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
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8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the bunal-transit	lical	d Aortic Stenosis			
39	leath certifica attending ph	Med	IF FEMALE:			
Box 6	ath ce ttendi	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy	23d. Date of delivery	
P.0.	at the de by the a tached f	Physician/Med	1 Yes 2 No 4 Pregnant at time of death 5 □ 9 Unknown	Other (specify)	Month Da	ıy Year
٣.	that the		Part II. Other significant conditions contributing to death but not resulting in the ur	iderlying cause given in Part I 23e	Did tobacco use contribute to the	cause of death?
ds,	uires tha signed t	d by	Coronary Artery Disease	. •	1 ☐ Yes 2 ☐ No 3 ☐ Probable	
Ö	w require been sig should to	ete				**
Ä	sician: The law certificate has b irector, page 2 s	Completed			Was an autopsy autopsy prior to comple death?	tindings available etion of cause of
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Division or Vital Records,	r Att	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, strubuilding, etc. (Specify)		ion (Street and Number or Rural R or Town, State)	oute Number,
	ital o	Š				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p	edical	29a. Certifier (Check only one) 1☑ Certifying Physician: To the best of my knowledge, death 2□ Medical Examiner: On the basis of examination and/or in and manner stated.	occurred at the time, date and place, and due to restigation, in my opinion, death occurred at the	o the cause(s) and manner as state time, date and place, and due to th	ed. e cause(s)
	o the	Med	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day	
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	_	-	30. Name and address of person who completed cause of death (Item 23a) (Type, I	D55148	August 29, 200	/
	3		Delroy Anglin, M.D., 1500 Forest Gler	Road, Silver Spring.	Maryland 20910-	1484
	Stat	e	Delroy Anglin, M.D., 1500 Forest Gler 31. Date filed (Month, Day, Year) AUG 3 1 2007 32. Registrar's Signature	and it	- J	
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Tarty leading to immediate cause in the part of the pa		/Medical		disease or condition resulting in death) a. JUST CFC DELICATION CONTROL OF THE C	
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			1- For State Registrar Amend 20b, perFT, G870, 8/31/	07 TT Cer	tificate of	Death		Reg. No.	
	Physic /Medi		ROSE		DO	RMAN	2. Date of De Month	29 2007 2007	3. Time of Death 6:15 P M
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	Funeral		NORTH OAKS HEALTH CENTER 5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	PIKESVI If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birt	BALTIMOR	
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	MD BALTIMORE B	BALTIMORE	10f. Zip Code		Т	10g. Citizen of What C	1 ☐ Yes 2 No
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	3		30. Name and address of person who completed cause of death (I	tem 23a) (Type, Pi	court (Road su	He 301	Baltona	TO MD ZIZOS
	Sta Registr	te ar	31. Date filed (Month, Day, Year) AUG 3 1 2007	gnature	Coestes				,
	3		Mod o T FALL	-	N. Contraction of the Contractio				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygie 2007. 1- State Registrar Amend 20b-c, perFH,g871, 9/7/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Florence 0740 A M 1)9715 30 2007 /Medical 4a. Facility Name (If not institution, give street and number) tarbor Hospital)

5. Social Security Number

227 600 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**△**M 2□ F 237443853 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~-** any injury or other freumatic eventual. 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits BAltimorE 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2/223 U54 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: BLACH 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be FLOYENCE 19a. Informant's Name/Relationship (Type, Print) ORUCH 17ER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/06/ 20b. Place of Disposition (Name of the place)

Date of Disposition of the place)

Date of Disposition of the place of the 6 20a. Method of Disposition Sept. 8, 2007 Long Pine, I X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Long Pine Cemetery 22. Name and Address of Facility Phill; PAWEA-thereor 21. Signature of Funeral Service Licensee E. OlUERS+ BAlto MD 21213 Part1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Asma **Physician** Exace/Sation VAKAGONA /Medical Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Medical Certification: To Be Completed by Physician/Medical Examiner Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 212 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner burial-transit or Attending Physicien: The law requires that the death certificate be executed P.O. Box 68760. Division of Vital Records, within 24 hours after death.

To the Funerel Director: After th
completely filled in by the funeral To the Hospitel

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29d. Date signed (Month, Day, Year)

3001 S. Hanover St. Balt

State Registrar

AUG31

29b. Signature and title of gertifier

Harbor Hospital

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 27904 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Month 28, June Audrey Darling Physician Aug 4:15 PM /Medical 4c. County of Death 4a. Facitity Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Springbrook Nursing Home Rockville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Days | Hours | Min. | June 1, 1922 | 9. Birthplace (State or Foreign Washington 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M X TF 85 579 14 0892 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Importent: if Item 27 ie marked other than "neturel", or Items 23a or 28a-f ehow any injury or other traumatic event, the Madical Evendent Procedure. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 📆 🎾 0 Director Maryland Rockville Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20852 United States 10401 Grosvenor Place Apt 514 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 Alo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes X☐XNo Specify: Specify:White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Government Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Annie Evans Rowland Darling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9603 Converse Court, Brandywine, MD 20613 Ellen Sabino (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept Pate 2007 20c. Location - City or Town, State 20a. Method of Disposition

1/□/Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Suitland, MD Cedar Hill Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc 6633 21. Signature of Funeral Service. Old Alexandira Ferry Road, Clinton, 200735 700153 1 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) Lymphoma **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical for use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of detivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by end stage renal disease 1 ☐ Yes \$\tilde{\tilde 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification; To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide after within 24 hours a

To the Funeral I

completely filled filled TEX certifying Physician: To the best of my knowledge, death occurred it the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Aug 28, 2007 D52261 30. Name and address of person who completed cause of de th (Item 23a) (Type Print) M.D. 1517 Hugo Cir., Silver Spring, MD 20906 Segal, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007	2790	
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		1- For State Registrar		Certifica	te of	Death				Reg. No.	200	1	2130
Physicia	an/	Decedent's Name (First, Middle	Marth Day Voor										
ledical Exami	ner		KUSI DAVIES					_,	August 9	, 2007)44 hrs
		4a. Facility Name (if not institution Rt. 197 Collington/ Eve	_		41	o. City, Town, Bowie	or Location	of Death			ounty of Deatl ce George		
• Funeral		5. Social Security Number	5. Sex 7. Age (In	yrs. last birth	day)	If Under 1 Y		er 24Hrs.	8. Date of B	irth(MM/DD/	YYYY) 9. Bir Forei		(State or
Director			1 M 2 F 22		Yrs.	Months D	ays · Hour	s Min.	2-24-	85			A LEONE
daryland 28a-f show any 1 at once,	ctor	Usual Residence of Decedent	GEORGE 10c	. City, Town o	r Locatio	n 10f. Zip Code	e			10a. Citizen	of What Cou	1 5	Inside City Limits Yes 2 No
th the Maryland 23a or 28a-f sho	Dire	15621 ELSMERE C	OURT			20716					Leone NI-CR		-CARD-
r death wi or items	Funeral	11. Marital Status 1 Never Married 2 Mar	12. Was Decedent Eve Armed Forces? 1 Yes 2 X		If Ye	Decedent of s, specify Cul	ban, Mexicar	n, Puerto I			Race - Amer White, etc.		dian, Black,
rs afte nral" miner	۵	3 Widowed 4 Divo	or Dates:	ed) 16a D		s Usual Occu			ork done		of Business	ACK	v
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other tian	ompieted	12TH GRADE		CAS	SHIE	R				5	SEARS		
5-0 led wi Hygie other	ပ	17. Father's Name (First, Middle, I	_ast)	· · ·					(First, Middle	, Maiden Sur	name)		
121 l be fi ental l arked	Be	JOSEPH DAVIES							AYLOR				
D 2 should and M 7 is m:	1	19a. Informant's Name/Relationsh JOSEPH DAVIES-F				Address (St						e; Zip C	Code)
MD and 2 sho tealth and tem 27 is		20a. Method of Disposition		20b. Place of	Disposit	tion (Name of		.bow	Date Page		ation - City o	r Town,	State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		1 X Burial 2 Cremation 4 Donation 5 Other Special Service L	ecify:	GEO. WA	ASH.	er place) CEMET	ERY	9-1	-07	ADEI	PHI, I	MD	
Baltil permit. Departm Imports	- 4	21. St. 2 - Of Purieral Service L	A Rayle	,		4 – 8TI							5236
Physician		23a. Part I. Enter the disease, or o		death. Do not								App	proximate Interval
/Medical		failure. List only one cause of Immediate Cause (Final disease	a. Multiple Injuries	ė.								Bet	tween Onset and Death
Examiner		or condition resulting in death)	Due to (or as a conseque	ence of):									
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseque	ance of):					-			+	
	miner	cause. Enter Underlying Cause (Disease or injury that initiated	c.	arice or).									
Si S A	Exar	events resulting in death) Last	Due to (or as a conseque	ence of):									11
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1760, ficate be of physicials the buria	ledi	IF FEMALE:	23c. If yes, outcome o	Og perF	H,G87	0,8/31/0	07,WS			23d D	ate of delive	rv .	
	an/M	23b. Was decedent pregnant in the past 12 months?		2	Fet	al death	3 Ectop	ic pregna	псу			Day	Year
O. Box 687 at the death certifi d by the attending	Physician	1 Yes 2 No 9 ✔ Unkr	4 Pregnant at time	of death 5	Oth	er (Specify)							
the de	P	Part II. Other significant condition	o dilitiowii	t not resulting	in the ur	nderiving cau:	se given in F	Part I.	23e. Did	tobacco use	contribute to	the ca	suse of death?
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tal Records cian: The law requi certificate has been ector, page 2 should	립		· · · · · · · · · · · · · · · · · · ·						per	opsy formed?	death?	·	etion of cause of
Re ifficati r, pag		25. Was case referred to medical				26.Pi	ace of Death	(Check o		2 No	1 🗸 Y	res	2 No
Vital Rec ysician: The his certificate director, page	o Be	examiner?	Hospital: 1 Inpatient	2 ER/Ou	tpatient		Other ₄		g Home 5	Residence	e 6 🗸 Othe	er: Scer	ne
n of \ding Phy. After th	\vdash	27. Manner of Death	28a. Date of Injury	28b. T	ime of In	ijury 28c.	Injury at Wo		28d. Describ				
Division of Vital Records, lal or Attending Physician: The law requir rs after death. al Director: After this certificate has been seled in by the funeral director, page 2 should the lab the funeral director, page 2 should the lab the funeral director.	Certification:	1 Natural 5 Pendi 2 ✓ Accident Invest	ng Aug 9, 2007	2037	hrs	1	Yes 2	₹ No	Pedestriar	1 Struck D	y auto		50.00
VISI or At after da Direct	tific	3 Suicide 6 Could	not be 28e. Place of Injury	- At home, far	rm, stree	t, factory, offic	ce building, e		or Town	State)			oute Number, City
Divi spital or . hours after neral Dir	Š	4 Homicide determ	Trans, Local		_				Rt. 197 Coli	ngton Road			way, Bowie, Md.
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certiful within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	ysician: To the best of my kn niner:On the basis of examina	owledge, deat ation and/or in	th occurr vestigati	ed at the time on, in my opir	e, date and p nion, death o	lace, and occurred a	due to the ca t the time, da	use(s) and n te and place,	nanner as sta , and due to t	ited. the caus	se(s)
To Wi	Me	29b. Signature and title of certifier	and manner stated.			29c. Lic	ense numbe	r	-	29d. Dat	e signed (M	onth, D	ay, Year)
		anet?				0.	C.M.E.			Augus	st 10, 200	7	
5		30. Name and address of person v Ana Rubio MD. Assi	who completed cause of death		enn C	treet, Balti	more Mr) 21201					
	ate		- AP		JIII J)	oro, IVIL	- 21201					
Regis		31. Date filed (Month, Day, Year)	307 Million J		No Sec								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No Z U U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death $\overset{\text{Day}}{1}\!0$, **Physician** ŽÖb7 9:12 August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 8-29- Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 KF 214-58-6628 Director with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director YD 1 timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r hraven Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: Never Married 2☐ Married 'natural", or 1 ☐ Yes 2 No Specify: <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ear. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Pages 1 and 2 should be file ment of Health and Mental H iant: If item 27 is marked oth Be INS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Bural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra harles 205. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State emeter 21. Signature of Funeral Service Licenses MO L 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a conse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 No 3 Probably 4 Unknown 1 Tes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2 **N**o 1∐ Yes Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 🔲 Yes 1 Inpatient 2 ER/Outpatient Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

Medical

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

Year)

Maryland 21215-0036

Baltimore,

P.O.

Records,

Vital

0

Division

Hospital

and manner stated.

(Item 23a)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

			For	State of M	arylan					1ental Hy	/giene	000-	
	ET 1 62215	-	For State Registrar			Cei	rtificate	of Dea	ath			2007	27907
	Physicia	an	Decedent's Name (First, Mide							2. Date of Do Month	Day		3. Time of Death
	/Medic		Charles Thoma							August			8:55 p ^M
	Examin	er	4a. Facility Name (If not instituti Stella Maris H	,					ation of Death			County of Dea	
1	Funeral		5. Social Security Number			last birthday)	If Under 1	onium Year If U	Inder 24 Hrs.	8. Date of Bi (Month, D		Baltimo 9. Bi	rthplace (State or Foreign
	Funeral Director		213-09-1856	1 🖾 M 2 🗆 F	101	Yrs.	Months	Days Ho	ours Min.	Oct.	a <i>y, Year)</i> 9.19 0		ountry) nnsylvania
	pu ,		Usual Residence of Decedent		I ton Cib	. Taus sala							
	aryla shov	_	MD 10b. Count	ltimore	100, 010	y, Town or Lo S	parro	ws Poi	int				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M 28a-f iotifie	ecto	10e. Street and Number				10f. Zip C				10a Citi	zen of What C	
	with sa or the r	ā	7405 North Po	int Road			101. Zip C	2121	9			USA	odnay:
	ms 2:	era	11. Marital Status	12. Was Decedent	Ever in U.	.S. 13. \	Was Decede			ecify Yes or N Rican, etc.)		14. Race - Am	
e 9	after or ite mIne	Fui	1 Never Married 2 Ma	Armed Forces' 1 Tyes 2 X If Yes, Give			r Yes, specir 1 □ Yes 2		exican, Puerto ec <i>ify:</i>	Hican, etc.)		Black, Wh	
5 р.ш 5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	3 ₩ Widowed 4 Divorce	d Year or Dates:									
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8:5	withi iene. than	шo	Elementary/Secondary (0-12)	College (1-4or	5+)		1 worl				Bet	hlehem	Steel Co.
7 pi	e filed Il Hyg other	Bec	17. Father's Name (First, Middle	e, Last)					Mother's Name	e (First, Middle			
8, 2007 Maryland	Vental	To B	John Doerr						Cora	Alexand	ler		
, 2 lary	2 shot and N is mar	i l	19a. Informant's Name/Relation	nship (Type. Print)		19b. Mailin	ng Address (Street and I	Number or Rur	al Route Numi	ber, City o	r Town, State,	Zip Code)
	and lealth m 27 her tr		Norma Jean Doe	rr- Daughter	Look 5	7405	Norht	Poin		Baltin			
ĭĭ	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		, 0	Place of Dispo cemetery, cren	natorý or oth	ner place)	1	Date		cation - City o	
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AU Ba	pe mit. Departr Im orta an inju		21. Signature de l'unierai servic	e Licensee						ıer-Dıp altimor			Home Inc.
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	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or mijer) that initiated events	Superior (or as	a conseq	defice of).							
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w w	rtifica ng ph as th	Ned	IE EEMALE.	-									
Вох	death certific attending p	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			Ectopic pre	gnancy			2	23d. Date of de Month	Day Year
0	The law requires that the death certifi ate has been signed by the attending bage 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of d	leath 5□	Other (spe	cify)				World	Day 16ai
σ.	that the de ned by the a	Ph)	Part II. Other significant condi	tions contributing to death I	out not res	ulting in the ur	nderlying cau	use given in	Part I.	23e. Did	tobacco u	ise contribute	to the cause of death?
DOERR ecords,	w requires to been signer should be a	d by								1 🗆	Yes 2	□No 3□F	robably 4XIUnknown
000	w red	Completed								24a. Was	s an	24b. Were a	utopsy findings available
	ician: The la certificate has rector, page 2	omp								perf	opsy formed?	prior to death?	completion of cause of
ARLE Vital		Be C	25. Was case referred to medic	al				26.	Place of Deat	1 Yes h (Check only	one)	1016	5 2 100
CHARLES or Vital R		To E	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati	ient 2 🗆	ER/Outpatien	t 3 DOA	Other: 4	☐ Nursing Ho	me 5□Res	idence (6 Other (Sp	ecity) HOSPICE
- 0	ing P		27. Manner of Death 1 ☑ Natural 5 ☐ Pend	28a. Date of Inj ing (Month, Da	ury ay Year)	28b. Time of Injury		c. Injury at Work?		28d. Describe	how injur	y occurred	
Sio	ttend Jeath. Stor: /	cati	2 Accident inves 3 Suicide 6 Could	tigation	ium. At ho	ome form str	M	1 ☐ Yes	2∐No	20f Longtion	(Ctmat am	al Alumbar or I	Ruml Boute Mumber
Division	lor A after o Direc	Certification:	4 ☐ Homicide deter	building, e	tc. (Specif	y)	cot, ractory,	Onioc		City or To	own, State)	Rural Route Number,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di			ing Physician: To the best									
	he Ho in 24 l he Fu pletel	Medical	(Check only 2 Medical	al Examiner: On the basis and manners		ation and/or in	vestigation, i	in my opinio	n, death occur	red at the time	e, date and	d place, and di	ie to the cause(s)
	To t To t	Σ	29b. Signature and title of certif	ier)			29c.	License nur	nber		29d. Dat	te signed (Mor	oth, Day, Year)
	a.		•	V/1-		_		ノ	2/2	J		8/27/	01
	7		30. Name and address of person	·	,								
) Sta	to	DR. TARIQ MAI 31. Date filed (Month, Day, Yea	r) 32. Regin	rar's Signa	EY VALI	4		MONIUM,	MD 21	093		
	Registr	ar	31. Date filed (Month, Day, Yea	3 1 2007	die	St.	Speake						

		For State	State of Ma	rylan				lealth a <i>Death</i>	nd Me	ntal Hy	gien	200	7	27908
2		Registrar 1. Decedent's Name (First, Middle, La	st)			HIIICa	e or i	Deam	2	. Date of De		200	,	3. Time of Death
Physicia	_		n A. Englur	nd. S	Sr.					Month August	28		ar	10:23 A M
/Medica		4a. Facility Name (If not institution, giv		,		4b. City	, Town, o	r Location of		iagas c		c. County of E	eath	10.25 /1
		6203 Rockhurst R				If I be also		nesda	VIII - 1 -			Mont		
Funeral		5. Social Security Number 6. S	Sex 7.Age IXM 2□F		last birthday, Yrs.	Months Months	r 1 Year Days	If Under 2 Hours	Min.	. Date of Bir (Month, Da	th ay, Year	9.	Coun	ace (State or Foreign try)
Director		508-20-7016 Usual Residence of Decedent		81					J	une 4,	192	6	Net	raska
yland how at		10a. State 10b. County		10c. City	, Town or L	ocation							10	Od. Inside City Limits
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d be fental l	To Be	Arthur Englund	,							te We		n oumanie)		
2 should be and Mental Is marked o	ř	19a. Informant's Name/Relationship (Type. Print)		19b. Maili	ng Addres	s (Street	and Numbe	r or Rural F	Route Numb	er, City	or Town, Stat	te, Zip	Code)
and 2 ealth a n 27 Is		John A. Englund,	Jr./Son		1 08 D	riftw	ood I	Orive,	Shi]	loh, N	ortl	h Caro	lin	a 27974
of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. P	lace of Disponentery, cre	osition (Na matory or	me of other plac	ce) S	ept.			ocation - City		
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permit. Depart Import any Inj once.		21. Signature of Funeral Service Licer		10019	98 7	obert 557 W	nd Addre A. ISCOT	ss of Facility Pumph nsin Av	rey F	unera. Bethes	l Ho da,	me/ ^{Bet} MD 208	nes 14-	da-Chevy Inc. 3501
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each line	the death e.	n. Do not en	ter the mo	de of dyin	ng, such as o	cardiac or r	espiratory a	rrest,			Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. <u>Hyperte</u> Due to (or as a	ensio	on								_	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. MEND TTPW/20b c. PEFH (870.8/31/07 NS and Mental Hygiene 27909 Certificate of Death Reg. NoZ 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month O8 **Physician** Year 9:52A M Eaton, Sr. Grayson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Good Samaritan Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex Birthplace (State or Foreign Country) **Funeral** Year) 1 M 2 □ F 220.52.2502 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at MD Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 rankford Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "n College (1-4or 5+) Elementary/Secondary (0-12) leacher Public Schools 12th grade tycars 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Moane Thomas Eator 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Frankford Avenue Sandra Batto. MD 20c. Location - City or Town, State Pikesville, MD 20b. Place of Disposition (Name of Drugger Property or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 09 01 107 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Vaughn C. Greene Funeral Services M01363 Baltimore MD 21212 4905 York 23a. Part1-Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed and burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2⊡ No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manny of Death funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t al or Attending Patter death. 5 ☐ Pending investigation 1 🗆 Yes 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature any 29d. Pate signed (Month, Day, Year) d cause of death (Item 23a) (Type, Print) mplet 31. Date filed (Month, Day, Year) 82. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2007 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3:48 P.M **Physician** August 27 Robert Thomas Fulton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford County 304 G. Forsythia Drive Abingdan If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1(XM 2□ F 82 219-12-5308 Vrs Baltimore, Maryland Director March 15, 1925 Usual Residence of Decedent with the Maryland 10a. State 10b Counts 10c. City, Town or Location 10d. fnside City Limits or 28a-f ehow th and Menta Hygiene. 27 te marked other than "naturei", or iteme 23a or 28a-1 ehov treumatic event, tra Medical Examinar must be notified at Maryland Harford County Abingdan 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 304 G. Forsythia Drive 21009 Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 (XYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 to Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 N/A Plumber H.A. Warfield 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be lik Department of Health and Menial Hy Important: if tem 27 is marked oth eny jinjury or other treumatic event 2008: 18. Mother's Name (First, Middle, Maiden Surname) John Fulton Anastasia Hockins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Patricia A. Punt (Daughter) 2107 Brandy Drive, Forest Hill, Maryland 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel Aug. 29, 2007 Forest Hill, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lem Peaceful Alternatives Funeral & Cremation Center, P.A. 2325 York Road, Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician nugo /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physicien and d be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of). Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No of Vital Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 🗌 Yes 2 00 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division s effer dea. 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) chmpletely filled in by within 24 hours e 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 032251 Au, 0, - 28, 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Relain m L. 5 W. MARRIA 31. Date fifed (Month, Day, Year) AUG 3 1 32 Registrar's Signature State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and a state of Marylandy Department of Mealth and Mental Hygiene 2007 1- State Amend 16a, 19a, perFD, g871, 9/11/07 Tertificate of Death Reg. No. 1. Decadent's Name (First, Middle Last) 2. Date of Death Month O **Physician** 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth (Month, Day, Year) June 17,1929 if Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Days Hours 78 Trento, Italy 230-34-2034 Director Usual Residence of Decedent r 28a-f show notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 XYes 2 □ No Bowie Director Prince George's MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be 20716 USA 16008 Pennant Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 No If Yes, Give Year or Dates: 1953 -55 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working Labor O NOT use retired) U.S. Gov. Elementary/Secondary (0-12) College (1-4or 5+) Labor Dept. Laborer Economist d 2 should be filed w h and Mental Hygie: 7 is marked other tf 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Micheli Daniele Flaim Maddalena 2 19a. Informant's Name/Relationship (Type. Print)

Lourdes Nieves Flaim Spouse

Outgood N. Nieves 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16008 Pennant Lane, Bowie MD 20716 Sept.1,2007 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages ' 1 Burial 2 □ Cremation 3 □ Removal from State Davidsonville,MD 4 ☐ Donation Lakemont Mem.Gardens 5 Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signatur of Funeral Service License 6512 NE Crain Hwy. Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as sonse wince of): 6 Mont Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and s the burial-tran Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy perform certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death.

Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

Hospital or Attending To the within 2

law requires that the death certificate be executed

Records, P.O.

or Vital

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

State

31. Date filed (Month, Day, Year)

Name and address of person

AUG

32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

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ORIGINAL

DHMH 17 Rev 1/2001

Registrar

			_ State	yland / Depa	artment of F	lealth and l		ene 2007	27912
			Registrar 1. Decedent's Name (First, Middle, Last) Compared to the compared			Dour	2. Date of Death	g. No. Day Year	3. Time of Death
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	ineral rector		555-26-2176 1□M 2X1 F 82	n yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 04/26/19	Year) 9. Birth Con	nplace (State or Foreign untry) MD
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е Магу	tified	ctor	MD BALTIMORE	RANDA	LLSTOWN				1 □Yes 2 No
with the	or 28 be no	Director	10e. Street and Number		10f. Zip Code	01100	10	g. Citizen of What Co	•
Jeath v	ns 23; must	Funeral	3826 ELMCROFT ROAD 11. Marital Status 12. Was Decedent Eve	er in U.S. 13.	Was Decedent of H	21133 lispanic Origin? (S	pecify Yes or No-	USA 14. Race - Amer	
ING 21215-UU36 be filed within 72 hours after death with the Maryland ntal Hygiene.	marked other than "natural", or Items 23a or 28a-f show matic event, the Medical Exam <u>lner must be notiffed at</u>	þ	Armed Forces? 1 □ Never Married 2 □ Married I □ Yes 2 M No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 💢 No	an, Mexican, Puert	o Rican, etc.)	Black, White Specify: W	, etc. HITE
5-0	"natur dical	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup	durina most of wor	king 1	6b. Kind of Business/I	ndustry
within iene.	than the Me	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retired HOMEMAKER	-/		OWN H	OME
nd 21 e filed wi al Hygien	other vent, 1	Be C	17. Father's Name (First, Middle, Last)				ne (First, Middle, M.		
Maryland 21215-003 Id 2 should be filed within 72 hours a Ith and Mental Hygiene.	narkec natic e	5	NATHAN	COHI		IDA	15 . N .		UEGER
Mar ar	27 is n r traun		19a. Informant's Name/Relationship (Type. Print) ROBIN SCHLOSBURG / DAUGHTER	I			GERMANTOW	City or Town, State, Z	′
altimore, M rmit. Pages 1 and 2 spartment of Health	: If Item 27 is marke or other traumatic		1 X Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo	osition (Name of CHYM ANSH FARD			Oc. Location - City or	
Baltimo permit. Pages Department of	Important: I any injury o once,		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		FARD 2. Name and Addre			OSEDALE, M ON & BROS.	
Balt permit. Departr	any onc		Routo Jahron		8900 REIS			IKESVILLE.	MD 21208
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ent	ter the mode of dyir			st,	Approximate Interval Between Onset and Death
-	sician edical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a c	ASTA	710	PERMO	ARCINO	MAdnas	
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pa	sit	iner	Equer tially list our Utilons, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events are utilise in doubl).	onsequence of):					
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8760 sate be e	physician and the burial-trans	dical	d						
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BOX	attending p	Physician/Me	in the past 12 months? 1 Very 2 No. 4 Pregnant at tim	Fetal death 3	□Ectopic pregnancy □ Other (specify) _	4		23d. Date of deli Month	Day Year
at the C	by the	hysi	9∐Unknown 3⊒Bilkilowii						
VITAL RECORDS, P.O. BOX 68/6U, sician: The law requires that the death certificate be executed	been signed by the should be detached	ρ	Part II. Other significant conditions contributing to death but n	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	accouse contribute to s 2 □ No 3 □ Pro	1
law re	as be	Completed					24a. Was an autopsy	prior to c	topsy findings available ompletion of cause of
	; certificate has l irector, page 2 s		OF Wassesser of sund Assessed and				perform 1□ Yes 2		2□ No
VII ysicia	is certi directo	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatier	nt 3 DOA Oth	or:	th <i>(Check only one)</i> ome 5 ☐ Residen) nce 6 □Other <i>(Spec</i>	eify)
C &	ifter th	no. T	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Y.	28b. Time o	of 28c. Injur		28d. Describe hov		,7
DIVISION OF all or Attending Phy after death.	tor: A	icati	2 ☐ Accident investigation	- At home farm stu		Yes 2 □ No	28f Location (Street	eet and Number or Ru	ral Route Number
DIV alor A	d in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury building, etc. (€	Specify)	oot, idotory, office		City or Town,		rai Houte Walliber,
DIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death.	Funers	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of response to the desire of examinary on the basis of example of the desire of example of the desire	amination and/or in	nvestigation, in my o	ppinion, death occu	rred at the time, da	te and place, and due	to the cause(s)
Fo the within 2	To the	Med	29b. Signature and title of certifier	Ta Aller	29c. Licens	e number	29	d. Date signed (Month	n, Day, Year)
			Malmin ons		D	5391	0	AUG-2	7 2007
	6	4	30. Name and address of person who completed cause of death	(Item 23a) (Type,	Print) 16RTHW	AST 1	DIPITAL	150 P.	1, Day, Year) 7, 2027 INDAUS TOWN
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's	Signature	EARL D		001/101	UIM WI	, , , , , , , , , , , , , , , , , , , ,
F	Registr	ar	AUG 3 1 2007 1000	July State of the second	Can - Raman				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 1 1 7

			1 - For State Registrar	State of Ma		Sertificate of		entai mygieni Reg. No		21913
	Physici	an	1. Decedent's Name (First, Middle, Las		aer			2. Date of Death Month Da	Year	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give		101	4b. City, Town,	or Location of Death	August 2'	. County of Death	15,15 PM
				way Cer		Bal	timore		Beitim	erl
	Funeral Director		5. Social Security Number 6. Se	7. Age M 2□F	(In yrs. last birth	Months Dave		8. Date of Birth (Month, Day, Year,	Po 1 100 1. 1. 1. 1.	/ ///
	ס		Usual Residence of Decedent 10a. State 10b. County		100 60 7			JUNE 15, 1		iomsport M
	Maryla f ehov	jo	NO. County	En ce	10c. City, Town	Location	4-11		1	1 ☐ Yes 2 No
	th the or 28a-	irec	10e. Street and Number	0.4		10f. Zip Code	10011	10g. Ci	tizen of What Cour	
	s 23a (must b	era [2735 Urey	Kd.		2	1161		USA	
9	after de or item odner r	Fune	11. Marital Status 1 Never Married 2 Married	12. Was Decedent E- Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		0 -	Hispanic Origin? (Spe pan, M exican, Puerto f	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
5-0036	filed within 72 hours after death with the Maryland Hygiene. uther then "natural", or Items 23a or 28a-f ehow ent, the Medical Examiner must be incitified at	Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1 □ Yes 2/2(No		750	Specify: W	rite
215	nin 72 In "nat Medic	piete	15. Decedent's Edit (Specify only highest grad	de completed)		ecedent's Usual Occu Give kind of work done ife. DO NOT use retire	pation during most of workir ed)	16b. K	ind of Business/Ind	dustry
2121	filed with Hygiene. Ither thai	Com	Elementary/Secondary (0-12)	College (1-4or 5+		ost mar	}	U.3	5. Post	al Service
land	buld be fil Mental H arked ott atlc even	To Be	17. Father's Name (First, Middle, Last)	n = ((22 -		Λ	(First, Middle, Maider	7 11	
Maryl	2 should be and Mental is marked calmatic ever	ř	19a. Informant's Name/Relationship (T		reag 196 M	Mailing Address (Stree	t and Number or Rura	Pline Route Number, City	or Town, State, Zip	
	1 and 2 Health em 27 l		Patrice Benne	et - sist		713 Ures	Rd, W	hite Hall	MAZ	1161,
Baitimore,	of of		20a. Method of Disposition 1 ☐ Burial 2 In Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	1 -	isposition (Name of crematory or other pla	(CO)		cation - City or To	WD 21050.
alt	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service Licens		Evanstu	neich (have 22. Name and ddr	ess of Facility	sport Dr., Fo	rest Hill	MD 21050.
	90 5 5 9		Rule by U. 3	aurothy		Evans Funero	it rapel+4	remation Se	rvices-Bel	Air
	Dhamisian		23a. Part . Enter the dis # se, or controls shock, or heart failule. List on your limmediate Cause (Final	ne cause on each line	ne death. Do noi	enter the mode of dy	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a	consequence of)	oma:				typans
	Examiner	_	Sequentially list conditions,	b	eansequeñes of)					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		GUI SEQUENIDE OT					
Ď,	e exection and urial-tr		resulting in death) Last	Due to (or as a	consequence of)					
98/PN	death certificate be executed e attending physician and id for use as the burial-transit	Medicai		d						
XOX	th certi		23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth 2		3 Ectopic pregnanc			23d. Date of delive	*
		Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at ti 9☐ Unknown		5 Other (specify)			Month	Day Year
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	sician: The certificate ha	e Co	25. Was case referred to medical				26. Place of Death	performed?	death?	2□ No
7 10	d is	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	t 2 ER/Outpa	itient 3 DOA Oth		e 5 Residence	6 □Other (Specify	<i>ı</i>)
	ding Ph h. After th funeral	tion:	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day	Yea <i>r)</i> 28b. Tim Inju	e of 28c. Injury Wo	ry at 2 rk? Yes 2 □ No	8d. Describe how injur		
UNISION	Atten	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur	y - At home, farm	, street, factory, office	_	Bf. Location (Street an	d Number or Rura	I Route Number,
5	spital or At ours after o neral Direc filled in by			building, etc.				City or Town, State		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Completely filled in by the funeral completely filled in by the funeral completely filled in by the funeral completely filled in the funer	edical	29a. Certifier 1 X Certifying Physics (Check only one) 2 Medical Exami	sician: To the best of ner: On the basis of e and manner state	ixamination and/o	eath occurred at the ti r investigation, in my o	me, date and place, ar opinion, death occurre	nd due to the cause(s) d at the time, date and	and manner as standard place, and due to	ated. the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier			29c. Licens	se number	29d. Dat	e signed (Month, L	Day, Year)
1	4		Wind Kleuz	mo			31295	8	128/07	
4	0		30. Name and address of person who co	mpleted cause of dea	ith (Item 23a) (Ty	pe, Print) Suite 42 o	3 Tows	md	2/204	
3	Sta Registra		Mende Month, Day, Year) AUG 3 1 200	32. Registrar	s Signature	rede				
	, region		MOU 9 7 500	. 200	5					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marviane P Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 30, 2007 11:00 A August Albin John Grden /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Parkville
If Under 1 Year | If Under 24 Hrs. Baltimore OakCrest <u>Village</u> Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. 1XM 2□F 12/15/1925 81 Director 218-22-3777 Maryland Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c, City, Town or Location 10a. State 10b. County show r 28a-f show notified at 1 ☐ Yes 2 No Director Parkville Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or 21234 United States 8830 Walther Blvd. Room 215 death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specity Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 7 Is marked other than "natural", or iten traumatic event, the Medical Examiner 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify. Specify: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Baltimore City Public 5± Music Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 John Grden Frances Oles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene C. Grden - Brother 4148 Norrisville Road White Hall, Maryland 21161 of Health 20b. Place of Disposition (Name of cemetery, crematory or other place)
Saint Stanislaus Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Department of Important: If it any Injury or o once. 1X Burial 2 □ Cremation 3 □ Removal from State 09/04/2007 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Cemetery 22. Name and Address of Facility
David J. Weber Funeral Homes P.A.
401 S. Chester Street Baltimore, Maryland 21231 21. Signature of Funeral Service Licensee 23a. Part 1 Enter the disease, or complications dial paused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician at the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Honknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 2 No certificate o the Hospital or Attending Physiclan: 25. Was case referred to medical 26. Place of Death (Check only one) director Be Hospital: 1 ☐ Inpatient Other: 4 Norsing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ဥ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0030972 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) week Blud Enkull MD 212 8800 wen K. Ging MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

1 2007

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ROME tant GROVEBEY 200 /Medical Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hosp:ta Baltimore llstown 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F Min Director Usual Residence of Decedent 10a, State 10b. County 2 should be filed within re ...
1 and Mental Hygiene.
7 Is marked other than "natural", or items 23a or 28a-f srum.
7 Is marked other than "natural", or items 23a or 28a-f srum.
7 Is marked other than "natural", or items 23a or 28a-f srum. 10c. City, Town or Location 10d. Inside City Limits Director timore 1 Yes 2 No MUD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Black. White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No 3 ☐ Widowed 4 ☑ Divorced Blac Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NQT use retired) ny/Secondary (0-12) College (1-4or 5+) ndsc or other traumatic event, 17. Father's Name (First, Middle 18. Mother's Name (First, Middle, Maiden Surname) Be COVE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Heatth a Important: If item 27 is any injury or other trau timare, MD 21217 1810 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State timore, MD 21. Signature of Funeral Service Licensee Funeral Services Hmare 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or he in failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** EREDIY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760 attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death Day Year 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate Division or Vital To the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 1 Matural 2 ☐ Accident After the funeral 28a. Date of Injury (Month, Day Year) 28h Time of Certification: Injury at Work? 28d. Describe how injury occurred within 24 hours after community to the Funeral Director: After To the Funeral Director: After Funeral Miled in by the fur 5 ☐ Pending investigation 1 ☐ Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check o y and manner stated. 29b. Signature and little of certifier 29c. License number ress of person who completed cause of death (Item 23a) (Type, Print) Cou 401 nt Rox STEVEN FULL OF onth, Day, 3 1 32 Registrar's Signature 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear Month Day 45 AM 30 2007 Florence Lee AUGUST 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOME CITIZENS HOURE NURSING GRACE HARFORD به مع (If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 □ M 2 F 220-22-5528 79 11/28/1927 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 📉 No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3524 Bay Drive 21220 S. A.

14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George W. Weber Mary Spicer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Manfre (Daughter) 412 Hardin Drive Joppa, Maryland 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 9/1 2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 Lichard 1. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 01/4 munit CHRUMIL Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent premant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mayner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Funeral

Director

a or 28a-f show be notified at

r than "natural", or Items 23a the Medical Examiner must b

permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, it

Director

by Funeral

Completed

Be ဂ

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

for

Physician/Medical

þ

Be Completed

Certification: To

3 ☐ Suicide

4 Homicide

6 ☐ Could not be determined

Hospital or Attending Physician; After this To the Hospital or Attend within 24 hours after death To the Funeral Director;

00 EN

Records, P.O. Box 68760

State Registrar

29a. Certifier 1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1449:M 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Whinn 7 VV 32 Registrar's Signature (Month, Day, Year) AUG 3 1 31. Date filed 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

0

OCME

AUG

Laron Locke MD.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

ORIGINAL

111 Penn Street, Baltimore, MD 21201

			1 - State Registrar	State of Marylar	nd / Depa <i>Ce</i>	artment of F <i>rtificate of I</i>	lealth and N <i>Death</i>	lental Hygid Reg	ene 2007	27919
	Physici		1. Decedent's Name (First, Middle, La ROBERT	G. HOLT				2. Date of Death Month	Pay W Year	3. Time of Death
	/Medic Examin Funeral Director		212 = 12 · 0803	Prood.	. last birthday) Yrs.	4b. City, Town, or If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	4c. County of Death 1 Out imm 9. Birth Year) 9. Dirth You 9. Dirth You 9. Dirth	place (State or Foreign
	laryland show	or.	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ity, Town or Lo	ocation				10d. Inside City Limits 1 □ Yes 2 No
	with the M a or 28a-f be notifie	Directo	10e. Street and Number	more 1	nangic	10f. Zip Code	.00	10	g. Citizen of What Cou	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cuba	1.33 ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
-0036	hours aft tural", or al Examii	δ	3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 1 No If Yes, Give Year or Dates:		1 □ Yes 2 M No dent's Usual Occup	Specify:	T 4	Specify: Bic	ach
Maryland 21215-0036	within 72 iene. than "na the Medic	Completed	(Specify only highest grant Elementary/Secondary (0-12)		(Give	kind of work done of DO NOT use retired	during most of work d)	ing P		roducts Inc
and 2	d be filed ental Hygi ked other c event, tl	To Be Co	17. Father's Name (First, Middle, Last				18. Mother's Name	e (First, Middle, Mi	aiden Surname)	100000
Mary	and 2 should be ealth and Mental n 27 is marked o	ř	19a. Informant's Name/Relationship (Type. Print)	19b. Maili		and Number or Run		NaS City or Town, State, Zi	o Code)
	Pages 1 ar nent of Hea int: If item ; iry or other		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	cemetery, cre.	osition (Name of matory or other place	ce)	Date 20	Oc. Location - City or T	
Baltimore,	permit. P Departme Importan any Injur		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice	nsee	T tame	LLY CONE to 2. Name and Address	ss of Facility \		othian m	
25	4		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.			ng, such as cardiac	or respiratory arres		Approximate Interval Between Onset and Death
ì	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consec	quence of):	GESTIVE		FAIL	IRE	
	rted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec		27 915	EASE			
68760,	icate be executed physician and s the burial-transit	al Exar	that initiated events resulting in death) Last	Due to (or as a consec	quence of):	<u>.</u>				
	certificate ding phys	/Medical	IF FEMALE:	23c. If yes, outcome pf pregn	nancy					
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 2 □ Fet: 4 □ Pregnant at time of a 9 □ Unknown	al death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deliv Month	ery Day Year
rds, P	quires that in signed b	by	Part II. Other significant conditions of Type 2 3/6	ontributing to death but not res	sulting in the u	nderlying cause give	en in Part I.		cco use contribute to t	
Division or Vital Records,	The law requir te has been si age 2 should t	Completed	TYPE 2 DIF CHRUNIC K URINARY T	LONEY DE	SEATE			24a. Was an autopsy perform	prior to co death?	opsy findings available ompletion of cause of
Vita	sician: certifica irector, p	Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{Yes} \) No	Hospital: 1 □ Inpatient 2 □		Oth	or.	1 Yes 2		2 ☑ No
on or	ding Phy h. After this funeral d	tion: To	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injur	4 🗆 Nursing Ho	me 5 Residen 28d. Describe how	ce 6 □Other (Speci injury occurred	fy)
Divisi	lor Atten after deat Director	Certification:	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	e 280 Place of injunt - At h	 nome, farm, str ify)			28f. Location (Stre City or Town,	et and Number or Run State)	al Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after cleath. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier 1 ★ Certifying Pt (Check only one)	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, deat ation and/or in	h occurred at the tir vestigation, in my o	me, date and place, pinion, death occur	and due to the cau red at the time, dat	use(s) and manner as stee and place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier Myulf	dord. 1	MD.	29c. License	e number 0867	290	d. Date signed (Month,	Day, Year)
,	20		0 ,	,	m 23a) (Type,					21208
Q	Sta Registr		30. Name and address of person who MIGUEL SADOVN 31. Date filed (Month, Day, Year) AUG 3 1	32. Registrar's Sign	ature	carles			1	

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

14. Race - American Indian,

Black, White, etc.

12. Was Decedent Ever in U.S. Armed Forces?

death with the Maryland r 28a-f show notified at a or ns 23a o permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner: once. Baltimore, Maryland 21215-0036

1 - For State Registrar

10a. State

11. Marital Status

Director

Funeral

Physician

Examiner

Funeral

Director

/Medical

Physician /Medical Examiner

burial-trar Division or Vital Records, P.O. Box 68760, attending pl page 2

To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death

To the Funeral Director:
completely filled in by the

교	1 ☐ Never Married 2X Married	1 ☐ Yes 2 X No	il res, specify C	upan, Mexican, Fuer	o nican, etc.)	Black, Whi	ie, etc.					
l by I	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 □ Yes 2√√ N	lo Specify:		Specify: White						
Be Completed by	15. Decedent's Edu (Specify only highest grad	de completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry									
E	Elementary/Secondary (0-12)	College (1-4or 5+) 4	Personnel D	irector	₁₇₇	.J1 C.						
ပ္	17. Father's Name (First, Middle, Last)	т ,	rersonner D		ne (First, Middle, Mai	ederal Go	vernment					
To Be	Hayes M. Herschle	er			t Fenster	•						
	19a. Informant's Name/Relationship (T	ype. Print)	19b. Mailing Address (Stre				Zip Code)					
	Joan S. Herschler	/Wife		13717 Drake Drive, Rockville, Maryland 20853								
	20a. Method of Disposition 1 ☐ Burial 2 反 Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State Mont	ace of Disposition (Name of emetery, crematory or other gomery Crematorii	m, Inc. Augu	st 2/,	20c. Location - City or Town, State Bethesda, Maryland						
	21. Signature of Funeral Service Licens	M01360	22. Name and Add Robert A. Pt 300 W. Mo	ress of Facility Imphrey Fune ntgomery	ral Home/Roc Ave., Rock	kville, ville, M	Inc. 20850-2805					
	23a Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	lications that caused the death one cause on each line.	. Do not enter the mode of o	lying, such as cardia	or respiratory arrest,		Approximate Interval Between Onset and Death					
	disease or condition resulting in death)	a. Esophageal					18 months					
		Due to (or as a consequ	ence or):									
iner	Sequentially list conditions, if any, leading to immediate Cause, Disease or injury	bDue to (or as a consequ	equence of):									
хап	that initiated events resulting in death) Last											
dical	d											
ertification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)											
占	Part II. Other significant conditions co	entributing to death but not resu	Iting in the underlying cause	given in Part I.	23e. Did tobac	co use contribute to	the cause of death?					
ed by	1 □ Yes 2 N No 3 □ P											
omplet	24a. Was an autopsy pric performed? 1 Yes 20 No 1											
0	25. Was case referred to medical		1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)									
O B	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient 3 DOA	ome 5 X Residence	e 6 □Other (Spe	ecify)						
ation:	27. Manner of Death 11 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M 28c. In W	jury at /ork? □ Yes 2 □ No	28d. Describe how i	njury occurred						
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28f. Location (Stree City or Town, S	on (Street and Number or Rural Route Number, Town, State)									
Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
Me	29b. Signature and title of certifier	A	29c. Lice	nse number	29d.	29d. Date signed (Month, Day, Year)						
)		De	52234	At	igust 24,	2007					
	30. Name and address of person who c	ompleted cause of death (Item	23a) (Type, Print)									
- 1	Manish Agrawal	10606 Concord	Street #300	Kensingto:	n, Marylan	d 20895						

State Registrar 31. Date filed (Month, Day, Year)

AUG

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SHENISE HORTON 15 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A THE JOHNS HOPKINIS HOSPITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🔽 F Director MARYLAND 213-78-8254 8-3-1971 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits notified at 1 Yes 2 No N/A BALTIMORE Directo MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with i Department of Health and Mental Hygene. Important: If them 27 is marked other than "natural" or items 23a or any injury or other traumatic event, the Medical Examiner must be not pillury or other traumatic event, the Medical Examiner must be not pillury or other traumatic event, the Medical Examiner must be not pillury or other traumatic event, the Medical Examiner must be not pillury or other traumatic event, the Medical Examiner must be not pillury or other traumatic event, the Medical Examiner must be not pillury and pillury 120 N. DALLAS ST. 21231 USA Funeral Race - American Indian Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 þ Specify: BLACK 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) CLERICAL JUVENIAL SERVICE -11-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ CECELIA A. SMITH HOWARD O. HORTON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1010 W. BALTIMORE ST. APT 509 BALTIMORE, MD 21223 HOWARD O. HORTON (FATHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Crematio 3 Removal from State 4 Donation 5 Other (Specify) ZION CEMETERY 8-31-2007 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee JONATIAN .D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. 23a. Party. Enter the dis shock or heart failu Immediate Cause (Final Physician Anoxic DAXS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner vere Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 🗌 Yes 2X No 3 Probably 4 Unknown certificate has been si irector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Funeral Director: etely filled in by the 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only within 24 h To the Fur 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier BES-000 MEDICAL DOCTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRISHENA JONES, THE JOHN'S HOPKINS HOSPITAL, GOONERTH WOLFESTREET, BALTIVAORE, MARYLAND 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State AUG 3 1 Registrar

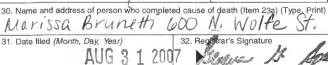
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State Registrar Amend #1, perMD, g870, 8/31/07 TT 1. Decedent's Name (First, Middle, Last) Patrick Andrew Jones, Jr. 2. Date of Death 3. Time of Death Year Physician Month 4ugust 2007 949 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore

Waar If Under 24 Hrs. John Hopkins Hospital
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F Yrs 1 29, Director 2005 220-73-2148 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Maryland Harford Joppa 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or 1112 Clayton Road 21085 Funeral USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Item 27 is marked other than other traumatic Elementary/Secondary (0-12) College (1-4or 5+) Never Worked 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be ည Patrick Andrew Jones Sr. Ashley Nicole Strozyk Department of Health and Department of Health and Important; If Item 27 is my any Injury or other 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1112 Clayton Road, Joppa, MD 21085 Patrick A. Jones Sr. / Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1⊠ Burial 2 □Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jarrettsville Cem. 8-25-07 Jarrettsville, MD 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician poplastic 1) months /Medical Due the or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of day, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the death certificate be executed Due to (or as a consequence of): burial-Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 Yes 2 No 9 Unknown signed by the Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by disease 2 No 3 Probably 4 ☐Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No Sepsis 24a. Was an autopsy page perform or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Inpatient ို 2 ER/Outpatient 3 DOA 27. Manner of Math 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident (Month, Day Year) 5 ☐ Pending investigation To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Trunettho Physician DO063275

State Registrar 31. Date filed (Month, Day, Year) AUG 3



Battimore, MD 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vear **Physician** KoBer NELL 1325 M 28 2007 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner BALtimure VAMEDICAL CENTER KALT: MURE NIA If Under 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, Year)
Months Days Hours Min. December 3, 1 5. Social Security Number 9. Birthplace (State or Foreign Country) 1944 Pennsylvania 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□F 159-36-1317 Yrs. Director 62 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show 1 ☐ Yes 2 XNo Director Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 "netural", or Itams 23a 6595 Pampano Drive permit. Pages I and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or itams 23.3 may injury or other traumatic event. Its Medical Examiner must sonce. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Air Purification Co. Elementary/Secondary (0-12) College (1-4or 5+) 12 years Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Blanche Morgan George William Knell ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6506 Pampano Drive, Glen Burnie, Maryland 21061 wife Valerie Knell 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State September 1 X Burial 2 □ Cremation 3 □ Removal from State Garrison Forest VA. 4, 2007 Owings Mills, MD. 4 ☐ Donation 5 ☐ Other (Specify) Connelly Funeral Home Of Dundalk, P.A 7110 Sollers Point Road, Dundalk, Md. 21. Signature of Funeral Service L die In 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Venous thrombosis to the /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician Physician/Medical the t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 2 🗌 No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 10 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this After thi funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be 3 TSuicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 8/28/2007 NPI: 1871701631 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 North GREENE STREET BALT, MURO, MD

State Registrar

31. Date filed (Month, Day, Year) AUG31 2007

GOORSEC, WILL'S

32. Rajistrar's Signature

Baltimore, Maryland 21215-0036

Box 68760.

P.O. |

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Kraft Kenneth 5:10 \mathbf{P}^{M} 28, 2007 August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 XM 2□ F 217-12-7238 82 September 26,1924 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Director Baltimore Nottingham Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21236 9133 Santa Rita Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White <u>۾</u> 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Esskay Butcher 10 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Myrtle Anita Young Anthony Griffin မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21236 9133 Santa Rita Road, Nottingham, Maryland Daughter Gloria Scrivani 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date September 1, 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State Baltimore City, MD. Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part1. Enter the diseas of r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) uncreatin **Physician** due to /Medical Due # (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform r Attending Physiclan: director, Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPIG 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours a er dealt e Funeral Lirector: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 29a. Certifier #E-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number

7 5 8 3 0 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) harks St DOWSON MD 21204 CAMMES State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Aug28, Physician 2352PR 2007 Dorothy Joyce Koppen /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Calvert Calvert Memorial Hospital Prince Frederick 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North 5. Social Security Number 9. Birthplace (State or Foreign Funeral 1 ☐ M 2 🌠 F Virginia 227 38 7801 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 TYes 2 TAN Maryland Prince George' Forestville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20747 2591 Oak Glen Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes XXXX If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No_X Specify: Specify White Completed by permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Sonce. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home Own 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Francis Georgia Ladd 10 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 318 Sunset Lane, Prince Frederick, MD 20678 Sharron Krouse (Daughter) 20b. Place of Disposition (Name of Sept 5, Date 2007 20c. Location - City or Town, State cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood, MD Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityLee Funeral Home, Inc 6633 21. Signature of Funeral Service Licenses Old Alexandira Ferry Road, Clinton, MD207B 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical years Due to (or as a consequence of): Examiner mom Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) 2 NO 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA ၉ 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation М 1 ☐Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funeral D 1 Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUNTING-TOWN 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Month Charles William Lowery August 27, 2007 8:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F Director 84 Maryland 215**-**16-4647 Feb. 28, 1923 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐Yes 2 XNo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 3 2501 Bounty Court Funeral 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married Married 1 ∐ Yes 21☑ No Specify: Ď 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Machinist U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Burton Lowery Hazel (nmn) Fier 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna L. Albrecht / Daughter 2501 Bounty Ct., Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 (A)Other (Specify) Bel Air Memorial Gdn 8-30-07 Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Fund al Service Licensee 50 W. Broadway, Bel Air, MD 21014 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Myccardial /Medical Due to (or as a consequence of): Examiner Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): years Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Dav 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? prantado autopsy performed? Yes 2 No Congeran 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Yes 2 Yo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) ie Hospital or Attending Pi 24 hours after death. ie Funeral Director: After ti 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

Mo mo 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29c. License number

Max Chai

29d. Date signed (Month, Day, Year)

	F		For State Registrar	State o	f Maryland		artment r <i>tificate</i>			nd Me	ntal Hyg	giene Reg. No.	2007	27928	8
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month au august 20 2007 /Medical . Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 30 If Under 1 Under 24 Hrs. lours Min. 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F **Director** 214-54-3138 9-18-1951 MARYLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. N/A BALTIMORE 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3108 REISTERSTOWN RD. APT 2 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Be Completed by Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -12-DISABLED DISABILITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN LEE SR. မ LILLIAN GARRISON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHYLLIS LEE (DAUGHTER) 4901 BOWLEND AVE. BALTIMORE, MARYLAND 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other 3 ☐Removal from State 5 ☐ Other (Specify) ZION CEMETERY 8/28/2007 BALTIMORE, MARYLAND uneral Service Licensee JONATHAN D. HIBNERName and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. P.rt1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm diate Cause (Final disease r condition resulting in death) **Physician** Coronary 1.5 years /Medical Due to (or as a conseque e of): Examiner disease End-stage ears Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): attending physician Physician/Medical as the l IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cancel 1 Yes 2 No 3 robably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 1[director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 **es** 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury at Work? 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0064231 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Estrella 600 N. Wolfe St. Baltimore, MD 21287 Michelle 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Bed # Registrar

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

Registrar

AUG 3

Physician /Medical Examiner Examiner

Physician

/Medical

10a. State

MD

Examiner

Funeral

Director

'natural'', or items 23a or 28a-f show dical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important; if Item 27 Is marked other than "natural"; or iter any injury or other traumatic event, the Medical Examiner

Baltimore, Maryland 21215-0036

Director

by Funeral

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physician and s the burial-transit I or Attending Physician: after death. Director: After this certifica

Division or Vital Records, P.O. Box 68760.

	shock, or heart fail to. List only one cause a each line.												
	Immediate Cause (Final disease or condition resulting in death)	a. NOW - SMALL Due to (or as a consequence of):	CELL LUNG	CANCER	Onset and Death 4 monTHS								
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edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
M	29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)								
	Nen M	wothe, MD	RES-00	O AUGUST ?	26th, 2007								

State Registrar NORTH WOLFE ST, BALTIMORE, MARYLAND 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KENNETH MWATHA

AUG

31. Date filed (Month, Day, Year)

600

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyand Decament of Health and Mental Hygiene Certificate of Death Reg. No.2 2. Date of Death Month 112. 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4a. Facility Name (If not institution, give 4b. City, Town, or Location of Death County of Death Examiner Baltimore LOWSON If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day **Funeral** 149-26-2176 Yrs. Balt, MARYIAND Director Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND BaltIMORE 1 ☐ Yes 2 ☐ No Director altmore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be n 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 es 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: WHITE <u>Ş</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any Injury or other traumatic event, the Mediconce. Elementary/Secondary (0-12) College (1-4or 5+) NATIONAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, HARD HAR 10 OHNSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RD. Balhmore, MD 21204 MACGICL 5Pous E THEL MEAD NDIAN Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) August 27 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐Removal from State FOREST HILL MARYLAND EVANS FUNERAL 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License PEACEFUL ALTERNATIVES FURNAL & CREMATION CM. PA Reso Timenum MD 2325 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** years 105 lastoma /Medical Du to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? res 2 7 No 1□ Yes or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) WISPLU Hospital: 1 ☐ Yes 2 ☑ No 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Funeral Director: After stely filled in by the funera 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours after 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ည 27 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST TONSON w 6701 - CHANKS N 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2007 Registrar

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. Box	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a			∃Ectopic pi ∃ Other (sp					'	Month	Day Year	
o.	at the de by the a tached	hys	9 ☐ Unknown	9□Unknown											_
S,	The law requires that the death certific te has been signed by the attending I age 2 should be detached for use as	ру Р	Part II. Other significant conditions of	ontributing to death b	ut not result	ting in the u	nderlying c	ause give	en in Part I.	2				he cause of death?	
Records,	equir en si ould b	ed									1 ☐ Yes	2 🗌 No	3 ☐ Prol	pably 4 Únknown	
ပ္ပ	law r as be 2 sh	plet								2	4a. Was an autopsy	24	b. Were auto	ppsy findings available mpletion of cause of	
Ŷ		Completed								1	performe	No No	death?	2 □ No	
Vital	sician; The law certificate has l irector, page 2 s	Be (25. Was case referred to medical examiner?							f Death (Che	eck only one)				_
	hysic this o	일	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpati		R/Outpatier			4 🗆 Nurs	ing Home 5	5 🗌 Residen	ce 6 □C	Other (Specia	(y)	
בַ	Ing P	:uo	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da		28b. Time o Injury		28c. Injury Work			Describe how	injury occ	curred		
Sio	tend eath. tor; / the f	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		44 h		M		Yes 2 □ No					18	
Division or	or At fiter d Direc in by	Certification:	4 Homicide determined	Zoe. Flace Of III	c. (Specify)	ne, rarm, str	eet, ractor	у, опісе		28f. LC	ocation (Stre City or Town,	et and Nui State)	mber or Hur	al Route Number,	
_	To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director, After this certifics completely filled in by the funeral director,		29a. Certifier 1 Certifying Ph	ysician: To the best	of my know	ledge deat	h occurred	at the tin	ne, date and	place and di	ue to the car	ISB(s) and	manner as s	tated	_
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	omple	Me	29b. Signature and title of certifier				290	c. License	number		290	d. Date sig	ned (Month,	Day, Year)	-
)	->-0		> Tiffanys	ridges M	10			Pic	7665	5		Au	9 27	2007	
	ار		30. Name and address of person who	completed cause of c	leath (Item 2							_			-
	15							212	01						
	Sta		31. Date filed (Month, Day, Year) A11G 3 1 2007	Greene St	ar's Signatu	ire d	20								
	Registr	te l'	41117.5 1 7.007	Part Stilled Town	a	A									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Anna Isabel McBrearty 28 2007 9:25 PM August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Yea 9. Birthplace (State or Foreign Country) 1915 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🗓 F 212-32-1270 92 June 16, Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Parkville 1 ☐ Yes 2X No Maryland Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 8800 Old Harford Rd. United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Year or Dates: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) administrative clerk public service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph P. Connor Sr. Anne McNicholas ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Quaker Hill, CT 06375 33 Milton Rd. Joseph McBrearty/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Dulaney Valley Mem Gard Sep. 1,2007 Timonium, Maryland ^{22. Name and Address of Facility}
Mitchell-Wiedefeld Funeral
6500 York Rd. Baltimore, 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Meumonia Physician montes /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by disease 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown CONDINA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? res 2 No death? 2□ No 1∐ Yes the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21 No 1 Inpatient 2 ER/Outpatient 3 DOA မ Hospia 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number un 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Balts m1 2,204 BMC 6701 32. Registrar's Signature 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Registrar

			Pleas	e Type or Pri							.egible.	
			1 - For State Registrar Amend 16a, pe				artment of I rtificate of		Mental Hy	ygiene Reg. No.	7007	27036
13			Decedent's Name (First, Middle,)				71770410 01		2. Date of D	eath	Year	3. Time of Death
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	Examin	er	4a. Facility Name (If not institution, g HOSPICE OF BALT	IMORE GILCH				TOWSON	l			TIMORE
	Funeral Director		5. Social Security Number 217-12-8212	. Sex 7. Ag 1 □ M 2 1 F	e (In yrs. I 83	ast birthday Yrs.	If Under 1 Year Months Days		(Month, E	irth <i>bay, Year)</i> 5/1924	9. Birth Cou	place (State or Foreign ntry) MD
	D		Usual Residence of Decedent			, Town or L			0//10	7/1324		
	//anylar f show ed at	o	MD BALTI	MODE								10d. Inside City Limits 1 ☐ Yes 2X No
	n the l	irect	MD BALTI 10e. Street and Number	TURE	DAL	TIMOR	10f. Zip Code			10g. Citiz	en of What Cou	ntry?
	ath wil	ral D	715 MAIDEN CHOI			- 1		228			USA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1		S. 13.	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No		pecity Yes or N to Rican, etc.)		 Race - Ameri Black, White, Specify: 	
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nd	17. Father's Name (First, Middle, Last) SAMUEL DALEVITZ 18. Mother's Name (First, Middle, Maiden Surname) DALEVITZ											IEBOWITZ
Maryland	should be ind Mental ind Mental is marked o	오	19a. Informant's Name/Relationship	(Type, Print)			ing Address (Street		ural Route Num	ber. City or		
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Baltimore,	Pages 1 and the control of the control of the control or other control or		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	☐Removal from State	C	e <i>metery, cr</i> e	osition (Name of matory or other pla		Date		ation - City or T	
	artmen artmen ortant; injury		4 □ Donation 5 □ Other (Spe 21. Signature → uneral Service Lice		HEE		OUNG MEN 2. Name and Addre	i	0/2007		IMORE, & BROS.	
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	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	ily one cause on each li a	ne. KCA1	50 C	ter the mode of dyi	ing, such as cardia	c or respiratory	arrest,	(Approximate Interval Between Onset and Death Mon Hus
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P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	⊒Ectopic pregnanc ⊒ Other (s <i>pecify</i>) _	Sy.		23	3d. Date of deliv	ery Day Year
Records, P.	w requires that the de been signed by the should be detached	by	Part II. Other significant condition	s contributing to death b	ut not resu	Ilting in the	underlying cause gi	ven in Part I.			se contribute to t	he cause of death?
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· Vita	ysiciar s certif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 🗆 I	ER/Outpatie	nt 3 DOA Otl	26. Place of Dea	ath <i>(Check only</i> Home 5 ☐ Res		Other (Speci	n h ospice
n or	Attending Physician: r death. ector: After this certifics by the funeral director, p	-	27. Manner of Death ↑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry	28b. Time Injury	of 28c. Inju	iry at rk?	28d. Describe		1	mrestie
Division or	To the Hospital or Attending Physician: The within Exhours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e Place of ini	ury - At ho c. (Specify	me, farm, si	M 1 □]Yes 2□No		(Street and own, State)	l Number or Rur	al Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical (29a. Certifier (Check only one) Certifying C Medical Ex	Physician: To the best taminer: On the basis of and manner st	f examinat							
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	12		30. Name and address of person w	HARLESI	, and	23a) (Type	701 N	Chances	St	RWS	son m	Day, Year) 8 2007 0 21204
	Sta Registr		31. Date filed (Month, Day, Year)	1 2007 Regist	ars Signal	ture	Agenti					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** LOUISA M. MARR 4:38 PM 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner UNION MEMORIAL HOSPITAL BALTIMORE BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 25, 1 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M XXX F 219~14~0091 85 1922 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show at MXYes 2 □ No ns 23a or 28a-f sh must be notified Director Maryland Baltimore City Baltimore City 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? r than "natural", or items 23a the Medical Examiner must b 3848 Elmlev Avenue 21213 USA 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2XXXVo Specify à X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 9 vrs. N/A Ward Clerk Hospital permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygie Important: If item 27 is marked other t any injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George C. Phillips Jennie Desell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 Essexwood Ct. Baltimore, Norman J. Marr, Jr. (Son) Md. 21221 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 9-4-07 4 Donation 5 Dother (Specify) Most Holy Redeemer Baltimore, Md. 21. Signature of Funeral Service Lightsee ^{22. Name and Address of Facility}
Lassahn Funeral Home as 7401 Belair Rd. Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 30 400s 14 /Medical Due to (or as a consequence of) Examiner ute mo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi Pulmonor Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Miknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy performed 1□ Yes 2□No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident al or Attend after death filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of co

State Registrar

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DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item_23a) (Type, Print)

32. Registrar's Signature

1402

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Thelma Louise Mackabee August 28, 2007 5:55 A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Upper Chesapeake Medical Center Harford Birthplace (State or Foreign Country) Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1 □ M 2 🗗 F 5, 1930 Director Maryland 212-28-8709 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits items 23a or 28a-f shov ner must be notified at 1 ☐ Yes 2 No Director Maryland Harford Forest Hill 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21050 **USA** 306 Willrich Circle Apt. L Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. other traumatic event, the Medical Examiner 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 1 ☐ Yes 2√2 No Specify Specify. ģ 3 Widowed 4 Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) <u>Mortgage Officer</u> 12 Finance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be flik tment of Health and Mental H tant: If Item 27 is marked oth Hazel (unk) McQuay William Henry Kispert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2232 Frin Way, Bel Air, Maryland 21015 Karen L. Taylor / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page Department o Important: If any injury or 1 Seburial 2 ☐ Cremation 3 ☐ Removal from State Darlington Cemetery 8-31-07 Darlington, Maryland 4 ☐ Donation 5 ☐ Other (Specify) McComas Funeral Home, P.A. 21. Signatura 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MECHANICAL DISSOCIATION ELECTRO **Physician** /Medical Due to (or as a consequence of): WITH METASTAGIS TO BRAIN Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran Due to (or as a consequence of): Physician/Medical the as IF FEMALE: JSe S 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year for in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably → Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s perforn 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) Hospital: 1 ☐ Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Vital Division or

Hospital or Attending hours after within 24 hours at To the Funeral D completely filled i

29a. Certifier (Check only one)

29b. Signature and title of certifier

and manner stated.

29c. License number 26191

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. ANUSHA - SIRITHARA 260 CATEURY DRIVE, SUITE 21/22 B, BELAR, MD 21014 ANUSHA SIRITHARA 32. Registrar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar				, , , , , ,	Cei	rtifica	te of	Death		oman my	Reg. N	200	7	27	940
f	Physici	an	1. Decedent's Name (First			111.							2. Date of De	ath Da	y Y	ear		of Death
	/Medio		4a. Facility Name (If not in	Leat		llins	3		4h Cit	v Town o	r Location o		August	- 1	2007 County of	Death	1:45	5 A M
	Examir	er	1020 Brice		0.00000.000						ville						mery	
	Funeral Director		5. Social Security Number 227–30–0726	6. 5	Sex 1 □ M 2 🙀 F	7. Age (1		ast birthday) Yrs.		er 1 Year	if Under: Hours	Min	8. Date of Bir (Month, Da October	v. Year)	9	. Birthp	lace (Stat	e or Foreign
	ъ		Usual Residence of Deced															
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	eath is 23	eral	1020 Brice	Koad	12. Was Dec	redent Eve	ar in II S	13 1	Nas Dec		852	ain? (Sne	cify Ves or No		Ited S			
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	1 Never Married 2 3 Widowed 4 Di		Armed F	orces? 2 📉 No live	51 111 0.0	1			an, Mexicar Specify:	i, Puerto	cify Yes or No Rican, etc.)		Black, Specify:	White,	etc.	
Baltimore, Maryland 21215-0036	n 72 hou n "natura ledical E	Completed	(Specify only		ade completed)			16a. Deced (Give life. l	dent's Us kind of v	sual Occup vork done use retire	oation during mos	t of worki	ng	16b. K	ind of Busin	ess/In	dustry	
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b	e filed al Hyg othe	Be C	17. Father's Name (First, I	Middle, Las	1)						18. Mothe	r's Name	(First, Middle	, Maiden	Surname)			
ılar	uld be Venta rked ric ev	To B	James Boggs	S							D	ora l	Robinso	n				
lary	2 sho and h is ma	•	19a. Informant's Name/Re					19b. Mailir	ng Addre	ss (Street	and Numbe	er or Rura	I Route Numb	er, City o	or Town, Sta	ate, Zip	Code)	
Σ	and 2 ealth n 27 i		Gervis H. Mu		s / Hus	sband							lle, M					
ore	00		20a. Method of Disposition 1 🖾 Burial 2 ☐ Cren		∃Removal from	State	ce	ace of Dispo metery, crer	natory o	r other pla	ce)	Septen	ate iber	20c. Lo	ocation - Cit	y or To	wn, State	
E.	Pag tment tant: jury o		4 □ Donation 5 □ C	ther (Speci	fy)		Park	lawn Me				4, 20	007	Roc	kville	e, 1	1ary1	and
3ali	permit. Pagi Department Important: It any injury o		21. Signature of Funeral S	Service Lice	nsee	1	O.F.	Ro	bert	A. Pun	ss of Facilit nphrey	Funer	al Home/	Rockv	ille, I	Inc.		
	HD = 10 G		23a. Part1. Enter the dise shock or heart failur	ASS OF COR	anlications that	M013		130	Mac	r Mon	toomers	ATTON	ne Rock	37 11 14	e, Mary	land		
	Physician		Immediate Cause (Final disease or condition	re. List only	_a. Pt	ulmon	ary	Fibro		odo or dyn	19, 30011 03	- Cararao C	respiratory a	11031,			Approxin interval E Onset ar 5 Yea	id Death
	/Medical Examiner		resulting in death)			(or as a c											10 **	
19	445	Examiner	Sequentially list conditions if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events	s, te	D	o (or as a c		d Arth	riti	ls							10 Y	ears
68760, 5	icate be executed physician and s the burial-transit		that initiated events resulting in death) Last	l	c	(or as a c	onseque	ence of):										
687	rtificate ng phys	Medical		•	d													
P.O. Box	e death ce he attendii led for use	Physician/M	IF FEMALE: 23b. Was decedent pregn in the past 12 month 1 ☐ Yes 2 ☒ No 9 ☐ Unknown			birth 2 [nant at tin	Fetal	death 3	Ectopic Other (pregnanc (specify)	у				23d. D <i>a</i> te o Month		ery Day	Year
	s that the	P	Part il. Other significant o	conditions	contributing to	death but r	ot resul	ting in the ur	nderlying	cause giv	en in Part i.	,	23e. Did t	obacco i	use contribu	ite to tl	ne cause o	of death?
rds	quires n sign ald be	d by											1 🗆	Yes 2	X No 3[] Prob	ably 4	Unknown
or Vital Records,	The law requirate has been page 2 shoul	Completed											24a. Was auto perfo	psy prmed?	dea	th?		s available cause of
tal			25. Was case referred to r	medical							26 Place	of Death	1□ Yes (Check only o		1 🗆	Yes	2 No	.
>	ysick is cer direct	To Be	examiner? 1 ☐ Yes 2 💢 No		Hospital:] Inpatient	2 □ E	R/Outpatien	t 3 🗆 [OOA Oth	or.		ne 5 X Resi		6 ∏Other	'Specif	v)	
ion oi	ding Ph n. After th funeral	ation: T	27. Manner of Death 1 Natural 2 Accident	Pending investigatio		of Injury nth, Day Y	ear)	28b. Time of Injury	М	28c. Injui Wor 1 🗆		2	28d. Describe			Фросп	,,	-
Division	i Pite	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	288. Plac	e of injury ding, etc. (- At hon Specify)	me, farm, str	eet, facto	ory, office		2	28f. Location (City or To	Street ar wn, State	nd Number (or Rura	I Route N	umber,
	he Hospital n 24 hours a he Funeral pletely filled	Medical (29a. Certifier 1 C C (Check only one)	ertifying Pi ledical Exa	hysician: To th miner: On the l and mar	e best of r basis of ex nner stated	caminati	/ledge, deati ion and/or in	occurre vestigati	ed at the ti on, in my o	me, date an opinion, dea	id place, a	and due to the ed at the time,	cause(s date an) and mann d place, and	er as s	tated. the caus	e(s)
	To the within To the company	ž	29b. Signature and title of	Certifier	1			MA	1 2	9c. Licens					te signed (/)
			30. Name and address of	person who	completed cau	ise of deat	h (Item :	23a) (Type,	Print)									

Registrar DHMH 17 Rev 1/2001

State

Carl I. Schoenberger, M.D.

31. Date filed (Month, Day, Year)

32. Registra

AUG 3 1 2007

16220

Frederick Rd. #213, Gaithersburg, MD

State Registrar

29c. License number

29d. Date signed (Month. Dav. Year)

D0060050

August 27, 2007

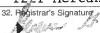
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mahrukh Hussain, M.D. 1221 Mercantile Lane, Largo, Maryland 20774

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

AUG 3 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) August 28 2007 ear **Physician** 5:02 A. M Renee Eulalie Mastalli /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 5135 Westbard Avenue Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🖾 F March 2, Director 98 1909 New York 140-01-5807 Usual Residence of Decedent 10c. City, Town or Location la or 28a-f show t be notified at 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 2. and 1. an United States 20816 5135 Westbard Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 2 X No 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify: Specify: White \$ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerical 12 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Adolph Rosemund Christine Elizabeth Frahm ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace L. Mastalli / Daughter 5135 Westbard Ave., Bethesda, Maryland 20816 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State August 31, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2007 Bethesda, Maryland Montgomery Crematorium, Inc. 21. Signature of Funeral Service License 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. M00896 7557 Wisconsin Ave., Bethesda, MD 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Failure to Thrive disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Heart Disease Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami attending physician and for use as the burial-tran Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Vear Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? 1 Yes 2 X No 2□ No 25. Was case referred to medical director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မှ 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, signed by the a has e 2 certificate this After thin 24 hours after death.

the Funeral Director: A
ompletely filled in by the fu within 24

the Maryland

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ava Kaufman, M.D., 8218 Wisconsin Ave, #103, Bethesda, Maryland 20814-3107

D26259

August 28, 2007

State Registrar

32. Registrar's Signatura 31. Date filed (Month, Day, Year) Sally Server AUG

07-06610 Andrea McNair

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State	Certif	ficate of De	ath		g. No.	
Physician Jedical Examine	ı/ er	Decedent's Name (First, Middle,Last) Andre Rodde	H MCNair,	McNaii		2. Date of Death Month August 26,	Day Year 2007	3. Time of Death 0222 hrs
	ľ	4a. Facility Name (if not institution, give s Johns Hopkins Bayview	street and number)		y, Town, or Location of timore City	Death	4c. County of Dea	th
Funeral Director	ŀ	5. Social Security Number 6. Sex 212. 94. (de 33 1) 1 X M	7. Age (In yrs. last		nder 1 Year If Under nths Days Hours	24Hrs. 8. Date of Birt	` 1Fore	irthplace (State or ign ountry)
land f show any	T	Journal Residence of Decedent 10a. State 10b. County NA		own or Location attmor				10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	<u> </u>	10e. Street and Number 7 S. CONKLIV	Avenue	10f.	Zip Code 21224	- 10	g. Citizen of What Co USA	untry?
r death wi	Fune	1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Yes, Give Yeer	If Yes, sp	edent of Hispanic Origi ecify Cuban, Mexican, 2 No specify:	n? (Specify Yes or No- Puerto Rican, etc.)	White, etc.	arican Indian, Black,
2 hours	Completed by	15. Decedent's Education (Specify only Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of	ual Occupation (Give k working life. DO NOT u		16b. Kind of Business Warel	
	Be Co.	17. Father's Nakod (First, Middle, Last) Andre R. McN	lair, Sr.			Name (First, Middle, N		
AD 2 sho 2 s			es/Mother	803 N	1. Rose St	operor Rural Route Num VEET Bal	timore 1	VD 21205
Baltimore, Normit. Pages 1 and Department of Healt Information of Healt injury or other training or ot		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State Cre	nce of Disposition (matory or other pla rden of 1	ace)	09/04/07	Balton - City of	ire, MD
		21 Signature of Funeral Service License 23. Part I. Injer the disease, or agmplic	MODGYY	3000	and Address of Facility Baltmo	re Street	Baltimor	eMD 21224
Physician Medical xaminer	1	failure. List only one cause on each Immediate Cause (Final disease a M		S	de of dyring, sacif as ca		ost, shook, of flear	Between Onset and Death
	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	ue to (or as a consequence of):					
eecuted nand - transit	Examiner	(Disease or injury that initiated C	ue to (or as a consequence of):					
<u> </u>	Medical			G871,9/1	2/07,WS		22d Date of delive	
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 Live birth 4 Pregnant at time of death 9 Unknown	2 Fetal de		pregnancy	23d. Date of deliver	Day Year
P.O. B s that the d gned by the	2	Part II. Other significant conditions	contributing to death but not resi	ulting in the underl	ying cause given in Pal			to the cause of death?
Division of Vital Records, P.O. Box 68 him 24 hours after death certif him 24 hours after death. The Funeral Director: After this certificate has been signed by the attending niplety filled in by the funeral director, page 2 should be detached for use as	Completed					24a. Was autop perfo	sy prior to rmed? death?	processing and the second of t
tal Rec	Be -	25. Was case referred to medical examiner?	spital:	· · · · · · · · · · · · · · · · · · ·	26.Place of Death (
n of Vinding Physical In Inc. After this effuneral directions	의	1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month Day Year)	R/Outpatient 3 28b. Time of Injury 0222 hrs	DOA Other 4 28c. Injury at Work'	? 28d. Describe	Residence 6 Other	er:
Divisior Divisior Division Septial or Attency Hours after death Inneral Director: y filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e Place of Injury - At hom	ne, farm, street, fac	tory, office building, etc		Street and Number or litate) nore St, Baltimore,	Rural Route Number, City
To the Hospital within 24 hours To the Funeral completely filler	Medical C	29a. Certifier 1 Certifying Physicial (Check only one) 2 Medical Examiner:	n: To the best of my knowledge On the basis of examination and	, death occurred a l/or investigation, in	t the time, date and pla n my opinion, death occ	ce, and due to the caus curred at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
To with To con	Me	29b. Signature and title of certifier	-200 ·		29c. License number O.C.M.E.		29d. Date signed (A	
7	-	30. Name and address of person who co Patricia Aronica-Pollak MD.			Penn Street, Ba	Itimore, MD 2120	1	
Star Registra	te	31. Date filed (Month 1769, Year) 200	32. egistrar's Signatur		9			

Physician /Medical Examiner

Funeral Director

State Registrar		State Of W		epariment o Certificate d	f Health and of Death		eg. Nota 🐧 🎧 🔭	1 0701
. Decedent's Name	(First, Middle, La	st)				2. Date of Deat	h 200	5. Timle of Death
	A	lbert Char	cles Nowa	k		Month August	27, 2007	
a. Facility Name (If	not institution, giv	e street and number)	4b. City, Tow	n, or Location of Dea		4c. County of De	
		ssey Park		1511-1-4	Chevy Cha			ntgomery
Social Security N		Sex 7.A IM∑M 2□F	ge (In yrs. last birth		ear If Under 24 Hrs lys Hours Min	. (Month, Day,	Year)	Birthplace (State or Fore Country)
212-30- sual Residence of			74 .			September	20, 1932	New York
0a. State	10b. County		10c. City, Town	or Location				10d. Inside City Lim
faryland	Montg	omery			Chevy Cha	se		1 □ Yes 2 🔼
De, Street and Nun	nber			10f. Zip Cod	le	11	0g. Citizen of What	Country?
	606 DeRu	ssey Park		15.111.5	20815			d States
 Marital Status Dever Marri 	ad 2M Married	12. Was Decedent Armed Forces	?	13. Was Decedent If Yes, specify	of Hispanic Origin? (S Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Hace - Al Black, W	merican Indian, hite, etc.
3 Widowed		If Yes, Give Year or Dates:	1954	1 ☐ Yes 2 📉	No Specify:		Specify:	White
	15. Decedent's E	ducation	16a. I	Decedent's Usual O	cupation		16b. Kind of Busines	
Elementary/Secon	ify only highest grandary (0-12)	ade completed) College (1-4or	5+)	Give kind of work do life. DO NOT use re	one during most of wo tired)	orking		
•		4	· .	ector of	nformatio			e Company
7. Father's Name (18. Mother's Na	me (First, Middle, M	Maiden Surname)	
0- 1-6		bert G. No		44-97			ces Wocel	
9a. Informant's Na			ŀ	-	eet and Number or R		•	
Mary B. Oa. Method of Disp	Nowak/ I	wile	20h Place of I	Disposition (Name a	, · · ·		20c. Location - City	aryland 20
1 ፟█ Burial 2 [☐Cremation 3 ☐	Removal from State	Gate Gate	, crematory or other	place) : A	ugust	·	·
4 Donation 1. Signature of Fu	5 Other (Specif		of Hea	aven Cemet		, 2007 S	ilver Spr	ing, Maryl Tuneral Hor
1. Signature of Fu	Terai Service Licer	\sim / .	40000	Bethesda-	Chevy Cha	se Inc	7557 WIsc	onsin Aven
23a Part1 Enter II	ne disease) or abril	The same of the sa						Approximate
shock, or hear mmediate Cause (lications that cause one cause on each	ine.		ayg, each ac calcul	io or respiratory arre	,	Interval Between Onset and Death
lisease or condition esulting in death)		- UI	ratory Fa a consequence of					
			Cancer).				7 Months
equentially list cor any, leading to im ause. Enter Unde	iditions, mediate	D	a consequence of	i):				, monene
ause (Disease or in at initiated events	njury	c						
esulting in death) L	ast	Due to (or as	a consequence of):	-			
		d						
F FEMALE:								
3b. Was decedent in the past 12			2 Fetal death	3 ☐ Ectopic pregn			23d. Date of o	delivery Day Year
1 ☐ Yes 2 ☐ 9 ☐ Unknown		4∐Pregnant a 9□Unknown	at time of death	5 ☐ Other (specify	//			
art II. Other signif	icant conditions	contributing to death I	out not resulting in t	the underlying cause	given in Part I.	23e. Did tob	acco use contribute	to the cause of death
		Diabetes	Mellitus	}		1 . ∑ Ye	es 2∐No 3∐	Probably 4 ☐Unkn
						24a. Was ar	24h Ware	autopsy findings availa
				***		autops	y prior fined? death	to completion of cause?
5. Was case refer	red to medical				00 Plans of Pa			es 2 No
examiner? 1 ☐ Yes 2 📉		Hospital: 1 ☐ Inpati	ent 2 ☐ ER/Outp	patient 3 DOA	Other:	ath (Check only one	ence 6 □Other (S	nocify)
7. Manner of Death	1	28a. Date of Inj	ury 28b. Ti		njury at Work?		w injury occurred	респу
1 X Natural 2 ☐ Accident	5 Pending investigation	(Month, Da	ay rear) in		l ☐ Yes 2 ☐ No			
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		jury - At home, farr tc. (Specify)	n, street, factory, off	ice	28f. Location (Str. City or Town	reet and Number or . State)	Rural Route Number,
_	y== V					ļ		
	1 Certifying Ph 2 Medical Exar	nysician: To the best miner: On the basis	of examination and	death occurred at the	e time, date and plac ny opinion, death occ	e, and due to the ca curred at the time, d	ause(s) and manner ate and place, and o	as stated. due to the cause(s)
(Check only		and manner s			ense number			·
(Check only one)	title of restr			290. Lid	ense number	29	9d. Date signed (Mo	กเก, บay, Year)
(Check only	title of certifier	(min	us XII	>				
9b. Signature and	vry	Sure completed cause of	n MI	>	D003675	8	August	27, 2007

DHMH 17 Rev 1/2001

State

Registrar

20-41

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 28, 2007 **Physician** ETHEL M. O'CONNELL 11:24 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GILCHRIST CENTER Towson Baltimore County 5. Social Security Number 8. Date of Birth (Month, Day, Feb 8, If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Days Hours 1 □ M 2 🗙 F 90 213-52-9182 1917 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f shov the Medical Examiner must be notified at Baltimore County Maryland Ruxton 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 7818 Ballston Road 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No White þ 3 Widowed 4 □ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Education Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Pages 1 and 2 should be fill treent of Health and Mental H tant: If item 27 Is marked oth permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any lighty or other traumatic evone. Ellwood Augustus Metz Clack 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan L. O'Connell 7818 Ballston Road, Ruxton, Maryland 21204 (Daughter) altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State Green Mount Crematory 8/31/2007 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Fune I Service Liberties Mitchelf wiefereld Funeral Home, Inc. Martin D. Lawson 6500 York Road, Baltimore, Macyland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Men Thu Immediate Cause (Final **Physician** disease or condition resulting in death) You /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Øother (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . Charles St. falto. Md 21203 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Bev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar Amend #30, I	State of Ma perDVR,g870.8/	iryland 31/07	d / Depa TT <i>Ce</i>	artment of F <i>rtificate of</i>	lealth <i>Death</i>	and Mo h	ental Hyو ا	giene Reg. No. 2 (07	27946
	Physici	an	Decedent's Name (First, Middle, Cecelia	R.	01	Brien				2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution,		- 0	brien	4b. City, Town, o	r Location	n of Death	August	27 , 20		1:05 a ^M
			Casey House				Rockvi1	.1e			Mont	gomer	У
	Funeral Director		5. Social Security Number 216-03-1406	1 M 2 X F	(In yrs. la	as <i>t birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Unde Hours	Min.	8. Date of Birt (Month, Day (arch 3	h v, Year) 0, 1914	9. Birthp Coun Marv	lace (State or Foreign try) land
ī	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation						0d. Inside City Limits
	Maryle f sho ied at	or			,							1	1 ☐ Yes 2 ☐ No
	r 28a- notif	irec	Md Montgo	пету		Sand	y Spring 10f. Zip Code	-			10g. Citizen of	What Coun	try?
	th with	al D	1311 Hennessy T	errace			208	60			USA		
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at one.	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie	If Yes, Give			Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	lispanic C an, Mexic Specif		cify Yes or No- Rican, etc.)		ce-Americ ck, White, fy: Whi	etc.
	72 hours natural' ilical Ex		3 ☑ Widowed 4 ☐ Divorced 15. Decedent's (Specify only highest	Year or Dates: Education grade completed)		(Give	dent's Usual Occup	durina ma	ost of workin	100	16b. Kind of B		
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2	be file tal Hy d othe	Be C	17. Father's Name (First, Middle, La	,						(First, Middle,	Maiden Surna	1	
yıa	Meniarke narke	L 2	Clarence		inge			Rel				1bert	
, Ma	1 and 2 should be filed withir Health and Mental Hygiene. Ism 27 is marked other than other traumatic event, the Me		19a. Informant's Name/Relationship Charles O'Brier			1	ng Address (Street) Pheasan						Code)
2	Pages 1 nent of He nt: If iten ry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		Ba 1	ace of Disponentery, cre	osition (Name of matory or other pla Cremato	ce) ry		ate	20c. Location	,	,
	nit. Pa artmer ortant injury		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Li		@ L	oudon ₂	Park 2. Name and Addre	ss of Fac	8/28/	udon Par	Baltimo rk Fune	re, M ral H	aryland ome
ב	permit. Depart Import any inj once.					3	3620 Wilk	ens A	Ave.,	Baltimo	ore, MD	2122	9
			23a. Part. Enter the disease, or conshock, or heart failure. List of	omplications that caused nly one cause on each lin	the death e.	. Do not en	ter the mode of dyi	ng, such a	as cardiac or	r respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)				ascular A	ccid	ent				Onset and Death
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	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequ	ence of):							
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5	rtificating phy	Media	IF FEMALE:										
	The law requires that the death certificate be executed the has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	/sician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome p 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 🗌 Fetal	death 3[□Ectopic pregnanc □ Other <i>(specify)</i> _	у			1	ate of delive onth	ery Day Year
	w requires that the de been signed by the should be detached	by Phys	Part II. Other significant condition	s contributing to death bu	ıt not resu	Iting in the u	nderlying cause giv	en in Par	t I.	23e. Did to	obacco use con	tribute to th	ne cause of death?
5	require		Hypertension							1 🗆 Y	es 2 No	3 ☐ Prob	ably 4 □Unknown
		Completed	Leukemia									prior to cor death?	psy findings available npletion of cause of 2310
A IEG	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			ot 3D DOA Oth			(Check only o		100	
5	g Phys er this eral dir	٦: T	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injur	y T	28b. Time o	III OLI DOA	4UI			lence 6 dot now injury occu		n HOSPICE
2	Attending Physician: The sr death. rector: After this certificate he by the funeral director, page	ation	1 Statural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no		Year)	Injury		Yes 2	□No				
	al or Att s after de al Direct ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ry - At hoi :. (Specify	me, farm, st	reet, factory, office		2	Ref. Location (S City or Tow	Street and Num n, State)	ber or Rura	I Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certificacompletely filled in by the funeral director,	Medical (29a. Certifier 1 ☐ Certifying (Check only one) 2 ☐ Medical E	Physician: To the best of xaminer: On the basis of and manner sta	examinat	vledge, deat ion and/or in	th occurred at the ti	me, date opinion, d	and place, a eath occurre	and due to the ed at the time,	cause(s) and m date and place	anner as st	tated. o the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	11.10			29c. Licens				29d. Date signe	ed (Month,	Day, Year)
1	D di		grenere 1	NUMB	· lu)		06	461.	2	August	28,	2007
T	2 (1)		30. Name and address of person w										
	Sta	te	Genevieve Anne Wrob 31. Date filed (Month, Day, Year)	32. Registra	y Hous ir's Signat	se, Koc	kville, MD						
	Registr	ar	AUG 3 1	2007 Line	nd de	r fly							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 27947 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** ANNA MARIE O'NEILL 28, 2007 4:50 A M AUG. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL CARROLL HOSPITAL CENTER WESTMINSTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours Min. 1 M 2 F 199-14-3811 Director 84 9/26/1922 PENNSYLVANIA Usual Residence of Decedent 10c. City, Town or Location or 28a-f show e notified at 10a. State 10h County 10d. Inside City Limits 1 □Yes 2√No Director CARROLL FINKSBURG MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 2 must be n Funeral 1602 GREEN MILL RD. 21048 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status "natural", or item edical Examiner ∟ Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: WHITE þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry th. Medical Elementary/Secondary (0-12) College (1-4or 5+) 12 HOUSEWIFE HOME MAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEWIS WINTERS HANNAH MAE MICHAELS ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT P. O'NEILL SON 1602 GREEN MILL RD., FINKSBURG, MD 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If its any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SANDY MOUNT CEM. 9/1/07 SANDY MOUNT, MD 4 Donation 5 ☐ Other (Specify) 21. Sgnature - Filneral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Part1. Intervie disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Seve-e **Physician** /Medical Due to (or as a consequence of): Examiner ocan Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed' death? 1 ☐ Yes 2 ☐ No 1□ Yes 2 - No 25. Was case referred to medical Be 26. Place of Death (Check only one)

law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

physician and s the burial-transi rector, page 2 within 24 hor To the Fune completely fi

examiner?

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

LÁTHA

4 ☐ Homicide

29b. Signature apositile of certifier

NAGANNA

P

Certification:

Medical

1 Yes 2 No

5 Pending investigation

6 ☐ Could not be

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

is marked

Health a

Baltimore, Maryland 21215-0036

State Registrar 2 ER/Outpatient

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

3□ DOA

М

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

D0061755

Hospital: 1 ☐ Inpatient

28a. Date of Injury

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Month, Day Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

8/30/

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 1.45 A M 2007 SAM PRICE, JR. AUGUST 24. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 205 N. AMITY ST. BALTIMORE Year If Under 24 Hrs.
Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**⊠** M 2□ F 218-70-5050 51 Director JUNE 11, 1956 NC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event the Marking I... 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Funeral Director MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 205 N. AMITY ST. 21223 USA 14. Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify. Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12TH LABORER LANDSCAPING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ SAM PRICE, SR. MILEY CAMERON 19a. Informant's Name/Relationship (Type. Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARLETHA CHANCE/SISTER 1667 POLES RD., ESSEX, MD 21221 3altimore, 20c. Location - City or Town, State 5500 O DONNELL ST. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/31/2007 BALTIMORE, MD 21224 BAYVIEW 21. Signature of Funeral Service License 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD Approximate Interval Between Onset and Death or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 1. Enter the discharge shock, or heart for the e. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) NCEN **Physician** 7 months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate causs. Error Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician; The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: nse s 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 No 3 Probably 4 Unknown Completed funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 21 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 № No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending investigation Injury 1 □ Yes 2 □ No death. 2 Accident 24 hours after death Pruneral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29071 8-30-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. EUTAW ST #305 BALTIMONE MO 2124 JAN 2. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

AUG 3 1 2007

			Please	Type or Print in I AMFND TIPM:/ perl State of Marylar	Black Indelible H,C870,8/31/0	e Ink. E	nsure Al	I Copies	Are	Legible.		
			For State Registrar	State of Marylar	Certificat			тептат ну		2007	27949	7
-36	Physici	an	1. Decedent's Name (First, Middle, Lat		1 -		-	2. Date of De	eath L Day	_ Year	3. Time of Death	_
	/Medi	cal	4a. Facility Name (If not institution, giv.	Picco		Town or Loo	ation of Death	Hugus	ST 6	28 200 County of Death	7 424512	_
	Funeral	ner	Franklin Sqn 5. Social Security Number 6/8	rane Hospi	tal	ROS	Under 24 Hrs.	8. Date of Bin	rth ay, Year)	Balt 9. Birth Cou		n)
	Director		Usual Residence of Decedent	0.00				4-16-	192		adelphiar	a
	farylar show ed at	'n	10a. State 10b. County		ty, Town or Location	200					10d. Inside City Limits 1 ☐ Yes 2 No	
	r 28a-f	irect	10e. Street and Number	nore 1	10TTINGY	Code		_	10g. Citiz	zen of What Cou	intry?	_
	ath with 23a o ust be	ral D	a Haspert	Road Ap	+ D 0	9123	(p)		1	USA		
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumafic event, the Medical Examiner must be notified at ore.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 例Yes 2	l.S. 13. Was Dece If Yes, spe 1 ☐ Yes		nic Origin? (Spilexican, Puerto pecify:	ecify Yes or No Rican, etc.)	0-	14. Race - Ameri Black, White, Specify:		
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2121	within iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ise retirea)				BGE	_	
	be filed ital Hyg id other event,	BeC	17. Father's Name (First, Middle, Last)					(First, Middle	, Maiden	Surname)		_
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Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tra		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	20b.	Place of Disposition (Nai	me of other place)		Date		cation - City or T		-
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Ba	Depariment of the period of th		21. Signature of Funeral Service Licer	Isee	22. Name ar 22. Name ar 8800 -	lact'	al Cha	pel + Cr Parku	ema	tion Se	rvices	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dear		de of dying, su			arrest,	1110 21.	Approximate Interval Between	
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	/Medical Examiner			Due to (or as a consec	juence of):	litic						
	p ##	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	juence of):	11-13-						_
	e executed ian and urial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consec	MMCHO!	<u> </u>						_
760,	ficate be ex physician a s the burial			.d								
x 687	ertifica ling ph e as th	Medi	IF FEMALE:		•							_
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of 6 9 ☐ Unknown	aideath 3 □Ectopic p				2	23d. Date of deliv Month	very Day Year	
	res tha igned be det		Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying o	cause given in	Part I.		· ·	1	the cause of death?	
or Vital Records,	w requir been si should	Completed by	Dententia					1 0	1		bably 4 Unknown	
Rec	sician; The law scertificate has be irector, page 2 s	Jdwo							psy ormed/?	prior to co	opsy findings available ompletion of cause of)
ital		BeC	25. Was case referred to medical examiner?			26.	Place of Deat	1 Yes n (Check only o	one)	1 ∐Yes	2 □ No	_
or V	Physician; r this certificaral director, I	P	1 Yes 25 No 27. Manner of Death	Hospital: 1 Inpatient 2 2	ER/Outpatient 3 DC					Other (Speci	fy)	
lon	nding F th. :: After e funera	tion:	1 □ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	Injury M	28c. Injury at Work? 1 ☐ Yes		28d. Describe	now injury	y occurred		
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, factor fy)	y, office		28f. Location (City or To			ral Route Number,	
	Hosp 24 hou Fune stely fil	Medical	29a. Certifier 1	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurred ation and/or investigation	l at the time, d n, in my opinio	ate and place, n, death occur	and due to the red at the time,	cause(s) , date and	and manner as a place, and due	stated. to the cause(s)	
	To the within ? To the comple	Med	29b. Signature and title of certifier	and manner stated.	296	c. License nun	mber		29d. Date	e signed (Month,	Day, Year)	_
	9		· _A	\geq	D	13761	2		8	12810-	7	
-	10+11		30. Name and address of person who	completed clause of death (Iter	n 23a) (Type, Print)	VI	90 1.01	e Driv	OP	altan	M 2102	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature Trur	IN III	yna	re DINV		10101	101 9140	1
	Regist		AUG 3 1 200	7 aller St.	(Care							

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dir

State Registrar 29b. Signature and title of certifier

m.D. Name and address of person who con

29c. License number

29d. Date signed (Month, Day, Year)

ed cause of death (Item 23a) (Type, Print) Snowlen Fiver MD

Harry Date filed (Month, Day, Year) 32 Registrar's Signature AUG 3 1 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 27,2007 Papa 8:07 Nancy August /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Riverview Care Center Essex 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 XF 83 Director March 25, 219-18-6339 1924 Maryland Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Director Baltimore Maryland Edgemere 10e. Street and Number 10g, Citizen of What Country? 10f Zin Code 2316 Lodge Forest Drive 21219 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cook Restaurant 8 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dominic Patucci Mary Aquino 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert W. Lingenfelder Nephew 2316 Lodge Forest Drive, Edgemere, Maryland 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) August 30, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 Removal from State Bayview Crematory Baltimore City, MD. 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 art1. Enter the disease, or complications that caused the death. By not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ut only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Kuow /Medical Due to (or as a consequence of): Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Ves 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an autopsy perform 1∏ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 27. Mannes of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury To the Hospina.
within 24 hours after deatr.
To the Funeral Director: Aft 1 Natural 1 ☐ Yes 2 ☐ No

Examiner be executed physician and s the burial-trans Box 68760, attending pl o ed by the a ۵. Records, has page 2 certificate or Vital Hospital or Attending Physician: 24 hours after death.

this

After

r 28a-f show notified at

than "natural", or items 23a or he Medical Examiner must be

the

marked other atth and Mental Hvr

Department of Health a Important: If item 27 is any injury or other trains

within 72 hours after

Pages 1 and 2 should

Baltimore, Maryland 21215-0036

5 Pending investigation 6 ☐ Could not be

M-D.

29a. Certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

2 Accident

3 Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALIKA WASSEM. 709. 1

BASTBAN BLUD- MD-21221

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** AUGUST BERNARD H PALM, SR. 26, 2007 6:20P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OAKCREST CARE CENTER PARKVILLE BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 **X**M 2 □ F 91 yrs. 215-10-8711 11-27-1915 **Director** MARYLAND Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at MD BALTIMORE Director PARKVILLE 1 ☐ Yes 2 ☑ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 8810 WALTHER BLVD APT. 1623 21234 U.S.A. Funeral r than "natural", or Items the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Ite 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: ps Specify: WHITE 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) JUDGE TRAFFIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ith and Mental h Be WILLIAM PALM CATHERINE (GALLAGHER) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BERNARD H. PALM, JR./SON IRISH CT BEL AIR, MD Department of Health Important: If item 27 any Injury or other trong once. 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH 8-30-07 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASCVO /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached t 9☐Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 donknown myelodysolasia certificate has been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed death? 1 ∐Yes 2 🖸 No 2 1No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Registrar

29b. Signature and title of certifier

Monias 31. Date filed (Month, Day, Year)

AUG 31

Anna

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

3altimore, Maryland 21215-0036

Records, P.O. Box 68760,

Division or Vital

DHMH 17 Rev 1/2001

Dance

Bus lever rol

We I ther

32 Registrar's Signature

29c. License number

058646

park ville

29d. Date signed (Month, Dav. Year)

MM 21234

07-06564 John Butler Patton

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

III Datier 1 att		1- For State Certification Cer	ficate of Death	Reg.	No.	01 213
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		Date of Death Month Date	ay Year	3. Time of Death 1945 hrs
⊶ical Exami	ner	John Butler Patton	The City To the Alexander	August 24, 2	2007 4c. County of Dea	
		Facility Name (if not institution, give street and number) 1404 Limit Ave	4b. City, Town, or Location of Baltimore	Death	4c. County of Dea	idi.
				24Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. E	sirthplace (State or
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last	Yrs. Months Days Hours	Min. 12/24/1	Fore	
ż.		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location			10d. Inside City Limits
Maryland 28a-f show any d at once.			ltimore			1 X Yes 2 No
yland a-f sh t once	Ş	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Co	ountry?
e Mai or 28	Director	1404 Limit Ave.	21239		USA	
with the Maryland us 23a or 28a-f sho be notified at once		11. Marital Status 12. Was Decedent Ever in U.S.	. 13. Was Decedent of Hispanic Origi		14. Race - Am	erican Indian, Black,
death with the Maryland or items 23a or 28a-f shomust be notified at once.	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican,	Puerto Rican, etc.)	White, etc.	
	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:		Specify: Wh	
5-0036 led within 72 hours after tygiene. other than "natural", c		to: Decedent's Education (opeon) and ingreet great temperaty	16a. Decedent's Usual Occupation (Give k during most of working life, DO NOT it		16b. Kind of Busines	s/Industry
136 hin 72 h e. than "r	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Marketing Directo	r	Telemark	etina
003 withingiene.	l mo	17. Father's Name (First, Middle, Last)		s Name (First, Middle, Ma		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	John Riley Patton	Vir	ainia Anne	Rutler	
ID 21215-003 should be filed within and Mental Hygiene. It is marked other the matic event, the Med	O E	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Num	ber or Rural Route Numb	er, City or Town, St	ate, Zip Code)
and 2 shou tealth and N	'	Timothy Kreider/Friend	PO Box 422, Charle	stown, MD	21914	
		Cr. Cr. Cr. Cr. Cr. Cr. Cr. Cr. Cr. Cr.	ace of Disposition (Name of cemetery, ematory or other place)	Date	20c. Location - City	
Pages eent of int: I		1 14()1		8/30/07	Parkvill	e, MD
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other ti		21. Signature of Funeral Service Literisee	22. Name and Address of Facility	 RUCK LOWS 	on Funera	1 Home, Inc.
(1)		23a. Part I. Enter the disease, or complications that caused the death.	1050 York Rd.,	IOWSON, MU	212U4 st. shock, or heart	Approximate Interval
Physician 'Medical		failure. List only one cause on each line.				Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Cocaine intoxicat Due to (or as a consequence of)				
		Sequentially list conditions, b.				
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0	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)				
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'60, ate be execut	Medical	X UNPENDED AMENDED #23a,27,28a-f. r	oerME,g871, 9/11/07 TT			
760, ficate be g g physicis			ancy	c pregnancy	23d. Date of deli	very Day Year
Box 687 e death certifithe attending if	Cia	past 12 months? 4 Pregnant at time of dea	2			
ision of Vital Records, P.O. Box 687 Attending Physician: The law requires that the death certific r death. ector: After this certificate has been signed by the attending I wy the funeral director, page 2 should be detached for use as th	Physician/	1 Yes 2 No 9 Unknown 9 Unknown		220 Did to	hacco usa contribute	e to the cause of death?
P.O. s that the gned by e detach	by P		sulting in the underlying cause given in Pa	art I. 23e. Did to		Probably 4 V Unknown
S, P uires t n sign Id be c	ed la					autopsy findings available
ords, aw requir as been a	ompleted			autops		
tal Recol	- 1 ()			1 ✓ Yes	2 No 1 🗸	Yes 2 No
Division of Vital Records, tat or Attending Physician: The law requir as after death. al Director: After this certificate has been selled in by the funeral director, page 2 should it led in by the funeral director, page 2 should it	Be (25. Was case referred to medical	26.Place of Death ER/Outpatient 3 DOA Other4		Residence 6 🗸 0	ther: Scene
of Viing Physi	-	1 V Yes 2 No Page 128a Date of Injury	28b. Time of Injury 28c. Injury at World		now injury occurred	
in of viding Ph. th. : After t	io iii	1 Natural 5 Pending Find 8/2//2007	Fnd 7:25 pm 1 Yes 2 X	No unk		
isio Atter rector by th	icat	2 Accident Pending Find 8/24/2007 28e. Place of Injury - At ho	ome, farm, street, factory, office building, e	tc. 28f. Location (S		r Rural Route Number, Cit
Div tal or ra after	Certification:	3 Suicide 6 X Could not be determined (Specify) found a	t home	or Town, S 1404 <u>Limi</u>	tate) Lt_Ave. B <u>alt</u>	imore, MD
Hospi 24 hou Funer tely fil	5	298. Ceruller	ge, death occurred at the time, date and pl	ace, and due to the caus	e(s) and manner as	stated.
Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Y completely filled in by the five	Medical	one) 2 Medical Examiner:On the basis of examination at and manner stated.				
F 3 F 3	🛎	29b. Signature and title of certifier	29c. License number		29d. Date signed	
		Pote () - toller	O.C.M.E.		August 25, 20	
Ø		30. Name and address of person who completed cause of death (Item Patricia Aronica-Pollak MD. Assistant Medical B		altimore, MD 2120	1	
	State	e 31. Date filed (Month, Day, Year) 32 Registrar's Signatu	ire			
Regi	stra		A STATES			
DHMH 17 Rev 1	/2001	OCME	ÓRÍGINAL			

07-06559 William Perry Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		For State		Certif	icate of	Death				teg. No.	200	
Physician/		gistrar Decedent's Name (First, Middle	e,Last)						Date of Dea Month	Dav	Year	3. Time of Death 1252 hrs
lical Examine		William Clinto	on Perry, I	II					August 24		atural Death	1202 1113
	48	a. Facility Name (if not institution	n, give street and numbe	er)		4b. City, Town, or	Location of	f Death		4c. Cou	nty of Death	
		4620 O' Donnell Street				Baltimore					N/A	place (State or
Funeral	5.	Social Security Number	6. Sex 7. A	Age (In yrs. last	birthday)	If Under 1 Yea		1 150			Foreign	
Director	2	13-70-3735	1 X M 2 F	51	Yrs	Months Day	s Hours	IVIII.	Oct.	26,195	5 Cou	ntry)
	-	sual Residence of Decedent										The state of the s
à à	_	0a. State 10b. County		10c. City, To	own or Locat	tion					ļ	10d. Inside City Limits
_ % &		MD N/A		Balt	imore							1 X Yes 2 No
yland -f sh	₹ -	0e. Street and Number				10f. Zip Code			11.11	10g. Citizen o	f What Coun	try?
ine Maryland n or 28a-f shi iffied at once	[] '	1 W. Conway St		٦/.			2120	01		USA		
r death with the Maryland or items 23a or 28a-f show any must be notified at once.			12. Was Decede		13 W	as Decedent of Hi	spanic Orio	nn? (Spec	ify Yes or N	lo- 14. I	Race - Americ	can Indian, Black,
or items 23	1	Marital Status Never Married 2 Ma		es?	If `	Yes, specify Cuba	n, Mexican	, Puerto Ri	can, etc.)	'	White, etc.	
or it	<u> </u>		1 Yes	2 X No	1	Yes 2X No	specify:			Spe	cify: Whi	te
after		Widowed 4 X Div 15. Decedent's Education (Spe-	or Dates:	completed) 1	6a Decede	nt's Usual Occupa	fion (Give	kind of wo	rk done		of Business/I	
natu Exan	ᄝᆜ	Elementary/Secondary (0-12)			during r	nost of working life	e. DO NOT	use retired	d)	и .		
6 n 72 n 72 ical	<u> </u>		College (1-4)	0101)	Home	e Improve	ement			Gla	ss Com	pany
5-0036 lled within 77 Hygiene. d other than the Medical	Completed by	10 7. Father's Name (First, Middle,	L net)				18.Mothe	r's Name (I	First, Middle	e, Maiden Sun	name)	
Hyge d off							Rosa	alie	Cathe	rine L	annon	
11215-0036 Id be filed within 72 hours after fental Hygiene. Tarked other than "raatural"; event, the Medical Examiner.		William C. Per 19a. Informant's Name/Relations	ry, Jr.		19b. Mailir	ng Address (Stre	et and Nur	mber or Ru	ral Route N	lumber, City o	r Town, State	e, Zip Code)
D 21 should I md Mei 7 is mai	-ı	Rosalie Perry-				Conway S						
MD and 2 sho alth and 2 sho an 27 is raumat		20a. Method of Disposition	nother	20b. Pl	ace of Dispo	osition (Name of c	emetery,		Date	20c. Loca	ation - City or	Town, State
Imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Interest 7 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once the result of the Properties.	- 1	1 Burial 2 X Cremation	n 3 Removal from	State Mo	ematory or o	other place)		8/28	/07	Ro1	timoro	, Maryland
Page Page nent o		4 Donation 5 Other S	Specify:	He		,	C					
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat injury or other traumatic event, the Medical Exa	J	21. Signature of Funeral Service	e Licensee			Name and Addre						
m 88 8 8		Attracy				5224 East						Approximate Interval
Physician	П	23 Par I. Enter the hear,	r complications that cau on each line.	sed the death.	Do not enter	r the mode of dyin	y, such as	cardiac or	respiratory	u., oo i,		Between Onset and Death
Medical		Immediate Cause (Final disease	Olumbaaia of	liver								
caminer		or condition resulting in death)	Due to (or as a co	onsequence of)):							
		Sequentially list conditions,	b	annouigness of	١٠.							
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execu an an	Medical	UNPENDED	AMENDED									
60, ate be	Ed l	IF FEMALE:	23c, If yes, ou	utcome of pregr	nancy						Date of delive	
876 tifica ng ph		23b. Was decedent pregnant in past 12 months?	the 1 Live bir	th	2	Fetal death	3 Ector	pic pregna	ncy	M	onth	Day Year
Box 687 death certific the attending of for use as the	sician			nt at time of de	ath 5	Other (Specify)				-		
BO e deat the at ed for	Phys		Inknown g Unknov			1 1 1 2 2 2 2 2 2	a siyan in	Dort I	23e D	id tobacco us	e contribute t	o the cause of death?
that the detach		Part II. Other significant cond	ditions contributing to	death but not re	esulting in tr	ie underlying caus	e given in	rait i.				obably 4 Unknown
res th	d by								1	Vas an		autopsy findings available
ords, v requir s been s should	ete								a	utopsy	prior to	completion of cause of
COI law has e 2 sh	ompleted									erformed? 'es 2 No	death?	
ral Records, san: The law require certificate has been s	S					26.PI	ace of Dea	th (Check	only one)			
cian:	Be	25. Was case referred to medie examiner?	11. 11. 1	patient 2	ER/Outpati	ent 3 DOA	Other ₄	Nursin	ng Home 5	Residence	ce 6 🗸 Oth	ner: Scene
of Vital ng Physician After this certi	٦	1 Yes 2 No	28a, Date of		28b. Time		Injury at W			ribe how injur	occurred	
1 of Ving Phy. After the funeral		27. Manner of Death 1 ✓ Natural 5 Pe	(Month,	Day, Year)			Yes 2					
Division tal or Attendins after death.	aţic		ending vestigation	71 · A16		street, factory, offi			28f Locati	ion (Street an	d Number or	Rural Route Number, City
ViSi or Att ifter d	iji.	3 Suicide 6 Co	ould not be	e of Injury - At n	ome, rarrii, s	street, ractory, one	Je ballaling.	, 0.0.		wn, State)		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Certification:	4 Homicide	etermined (Specify)								manner ee e	tated
Hosp 24 hc Fun		29a. Certifier 1 Certifying	Physician: To the best	t of my knowled	lge, death o	ccurred at the time	e, date and nion death	place, and occurred	a due to the at the time.	date and place	e, and due to	the cause(s)
To the Hos within 24 h To the Fur completely	Medical		and manner st	or examination a lated.	and/or inves					204 D	ate signed //	Month, Day, Year)
F. 2 F. 8	Me	29b. Signature and title of cert	tifier				ense numb	рег		1		
		Unumix (Mac (Koop)			0	.C.M.E.			Augu	ıst 25, 200	
		30. Name and address of pers	son who completed caus	se of death (Iter	n 23a)							
77		Margarita Korell MD		dical Exami	ner 11	1 Penn Street	, Baltime	ore, MD	21201			
d		Day Stand (Marette Day Vo		istrar's Signat		1. 4.						
	tate	TO COUNTY OF THE PARTY OF THE P	1 2007	Coline	1.	HORAL						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygier 007

						Cert	ificate of	Death		F	Reg. No.			
			1. Decedent's Name (First, Middle, Last,)						2. Date of Dea Month	ath Day	Year	3. Time o	Death
	Physici		Eva Virginia	Quast						August	27, 200	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	7:30	p.m.
	/Medi Examir		4a. Facility Name (If not institution, give	street and number)				4b. City, Tow	vn, or Lo	cetion of Death				
	- Autom		8810 Walther Bl	vd. Broa	adview	1121		Parkv	ille	9	Bal-	timor	е	
	Funeral		5. Social Security Number 6. Sec		ge (In yrs. last	birthday)	If Under 1 Year	If Under 2	4 Hrs.	O Date of Dist	h , ,	9. Birthp	lace (State of	or Foreign
	Director		217-09-0942	3M 2√7 F 8	38	Yrs.	Months Days	Hours	Min.	Feb.11	.1919	Mar	yland	
			Usual Residence of Decedent								,		J	
	yland 30w		10a. State 10b. County		10c. City, To	own or Loca	ation					10	0d. Inside C	ity Limits
	Mar A	ξ	Maryland Baltimor	е	Park	ville)						1 🗆 Yes	2 No
	1 the	ě	10e. Street and Number				10f. Zip Code				10g. Citizen of V	What Coun	try?	
	3a o		8810 Walther Blvd.	Broadvie	ou 11 <i>2</i> 1		21234				USA			
	rrs 2	Funeral Directo				13. W	as Decedent of H Yes, specify Cub	Hispanic Orig	in? (Spe	cify Yes or No-		e - America		
	fer c	Ē	1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🛣	No				Puerto	Rican, etc.)		k, White,		
21215-0020	within 72 hours after death with the Maryland ene. then "netural, or items 23a or 28a-f show he Modical Examiner must be notified at	δ	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1[□Yes 2XQ No	Specify:			Specify	« Whi	te	
ō	2 ho	P	15. Decedent's Edu	cation	16	Sa. Decede	nt's Usual Occup	pation			16b. Kind of B	usiness/Ind	lustry	
715	nin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)		E.)	(Give ki life. D(ind of work done O NOT use retire	during most d)	of worki	ng				
212	the iene	E	Elementary/Secondary (0-12)	College (1-4or	5+)	Home	Maker				Օար հ	Home		
	Hyg Hyg ent,		17. Father's Name (First, Middle, Last)					18. Mother	's Name	(First, Middle,	Maiden Surnam	re)		
<u>a</u>	d be ental	To Be	Albert Slink	man				Edit	h	Brou	חוי			
Maryland	shound Minari	-	19a. Informant's Name/Relationship (Ty		1	9b. Mailing	Address (Street					State, Zip	Code)	
Ž	d 2 an		Craig Quast / Son	,			ountry :				Valleva			sn.
á,	us 1 end 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other then "netural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition		20b. Place	of Disposi	tion (Name of		uau	Date	20c. Location -			טנ
ᅙ	nt of nt of : # it		M□ Burial 2 □ Cremation 3 □ F	temoval from State		•	de Ceme		1 5	3/30/07	Pikesvi	11-	M1	
Baltimore,	permit. Pages 1 end Department of Health Important: If item 27 eny injury or other tr once.		4 □ Donation 5 □ Other (Specify)	1 1	DIUI		<u> </u>			1/ 30/ 0 /				
Ba	Depariment Important	, j	21. Signature of Tuner of ervice License	"///			Name and Addre	•					rk Roa	
			(a)	aux	1	Ru	ck Tows	on Fun	eral	. Home,	Inc.Tou	uson,ľ	Md.212	204
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	ications that caused ne cause on each li	d the death. D	o not enter	the mode of dyi	ng, such as o	ardiac o	r respiratory ar	rest,		Approximat Intervel Bet	ween
-	Physician						_					į	Onset and	Death
A STATE OF THE PARTY OF THE PAR	/Medical		Immediate Ceuse (Final disease or condition	(es pira	Horv	1 fan lu	ve_				i		
н	Examiner		resulting in death)		Due to (or es							į		
	ъ #	iner	5 <u>=</u> 1.	C	ago							i		
J-dr	certificate be executed nding physician and use as the burial-transit	Examiner	Sequentially list conditions,). —	Due to (or as	a conseque	ence of).			*				
68760,	e exe		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
376	ate b nysic the b	Completed by Physician/Medical	that initiated events resulting in death) Last	'. ————	Due to (or as	a conseque	ence of):		*****			1	***	
9	ng p	Me										ļ		
30X	th cert tendin ir use	ar/		J										
B	death	SC	Part II. Other significant conditions con	tributing to death b	out not resulting	g in the und	lerlying cause giv	ven in Part I.		23b. Did t	obacco use co	ntribute to	the cause	of death?
P.0	The law requires that the death ete has been signed by the atte page 2 should be deteched for	چ	api aut L							101	res 2□ No	3 ☐ Prob	ably 4 🗆	Unknown
	s the	<u>م</u>	CRI, CHF, lung	mos										
Vital Records,	quire en sig	8	-							24a. Was a		ava	ere autopsy ilable prior i	to
ပ္ပ	s bec	Set								ponto		cor	npletion of o	ause
æ	he lav e has age 2	Ē								1 🗆 Y	es 2 No	1]Yes 2□	No
ta			25. Was case referred to medical					26 Place	of Death	(Check only or		,,_		
Ē	Physicien: rthis certific rral director,	o Be	examiner?	lospital:	ant 2 🗆 EB/	Outpatient	3□ DOA Ott	hor:			ence 6 □Oth	or (Specific	d)	
ō	E E E	: To	27. Manne of Death	28a. Date of Inju	ıry 28t	o. Time of	28c. Inju				ow injury occur		7	
on	ding F h. After funer	tor	1 ☐ Natural 5 ☐ Pending investigation	(Month, Da	y Year)	Injury		rk? ∣Yes 2∐N	io					
S	Attending or death. sctor: After by the fune	lica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inj	urv - At home	farm, stree	et. factory, office		- 2	28f. Location (S	treet and Numb	er or Rura	Route Num	ıber.
Division	or Attending I efter death. Director: After I in by the fune	Certification:	4 ☐ Homicide determined		c. (Specify)		,,,,,			City or Tow	n, State)			
	Hospital 24 hours 6 Funerel I		29a. Certifier 1 Certifying Phys	icies: To the hest	of my knowled	lae death o	occurred at the tir	me date and	niece a	and due to the o	ause/s) and ma	nner as st	ated	
	To the Hospital or At within 24 hours efter or To the Funerel Direct completely filled in by	edicai	(Check only 2 Medical Examination)	ner: On the basis of end manner st	f examination :	and/or inve	stigation, in my o	ppinion, death	occurre	ed at the time, o	late and place,	and due to	the cause(s	;)
	To the within 2 To the comple	Me	29b. Signature and title of certifien	one mannot su			29c. Licens	se number	_	2	29d. Date signe	d (Month, L	Day, Year)	
-	5 m co		X XX				100	7200	17	4	8/24/	300	7	
	U		0 101		La calla de la cal	\ (T = -	J-01		110		100	3-3	•	
	20		30. Name end address of person who co	repleted cause of d	leath (Item 23a	a) (Type, Pr こいんない	ND Och	Cus	1117	luc 10	8/28) Wevilu	m)		
			21 Date filed (Month Day Veer)	32			10			Ü				
	Sta	te	31. Date filed (Month Org Y31) 1 20)07 32. Segistr	ar's Signatura	A.D.	34/4							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** AUGUST RADOM 28 2007 5:15 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FUTURECARE CHERRYWOOD REISTERSTOWN
If Under 1 Year | If Under 24 Hrs. | 8. Date of BALTIMORE 5. Social Security Number 8. Date of Birth (Month, Day, Year) 08/02/1925 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🔀 F Hours 126-16-1152 82 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits if than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No BALTIMORE MD REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12020 REISTERSTOWN ROAD 21136 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No WHITE þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) CLERICAL \$TATE OF MARYLAND marked other iny Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be to Department of Health and Mental Important; If Item 27 is marked o MORRIS RATNER IDA HOFFMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANIS DOTEN / DAUGHTER EAST CHERRY HILL ROAD - REISTERSTOWN, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date NORTH LAUDERDALE, FL. 1 X Burial 2 □ Cremation 3 □ Removal from State 08/31/2007 STAR OF DAVID 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License <u>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</u> 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death Yes 5 Other (specify) 2 □ No the 9 I Inknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ HO 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day 1 Natural 1 🗌 Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At hon building, etc. (Specify)

Division or Vital Records, P.O. Box 68760. Hospital or Attending Physician: within 24

Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

At home, farm, street, factory, office

Location (Street and Number or Rural Route Number, City or Town, State)

31. Date filed (Month, Day, Year) State

4 Homicide

32. Registrar's Signature

Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	ate of Marylan	d / Depa		f Health and North	Mental Hyg	ien 2007	27957
	Dhysisi	20	Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day Year	3. Time of Death
	Physici /Medio		William Ziegler Rif					August	28 2001	
	Examir	ner	4a. Facility Name (If not institution, give street	. 7		4b. City, Town	n, or Location of Death	Λ	4c. County of Dea	God
1	Funeral		5. Social Security Number 6. Sex	7. Age (In vrs. I	ast birthday)	If Under 1 Ye		8. Date of Birth (Month, Day,	77 <i>6</i> 47) ()	thplace (State or Foreign ountry)
	Director		144-03-4443	^{2□ F} 89	Yrs.	Months Da	ys Hours Min.	04/14/	1918 Ne	w Jersey
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
	th the Maryland or 28e-f ehow	tor	MD Baltimore		ngsvil		*			1 ☐ Yes 2 No
	death with the Maryland one 23a or 28e-f show it must be positied at	Director	10e. Street and Number			10f. Zip Cod	le	10	0g. Citizen of What Co	ountry?
1	ath wi		11712 Cedar Lane			210			U.S.A.	
-	after dea or iteme	by Funeral	A	'as Decedent Ever in U. med Forces? ∭XYes 2 ☐ No	S. 13.	Was Decedent (If Yes, specify C	of Hispanic Origin? (Sp Suban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
# 938	urs af		- Court I I I I I I I I I I I I I I I I I I I	Yes, Give ear or Dates: WW]	I	1⊡Yes 2🛛	No Specify:		Specify: W	nite
3.H 5-0036	within 72 hours after ene. then "neturel", or ite	Completed	15. Decedent's Education (Specify only highest grade com	n ppleted)	(Give	dent's Usual Oc kind of work do	ne during most of work	sing	16b. Kind of Business	
121	d within giene. rr then	ldm		ollege (1-4or 5+)		DO NOT use re		G	lenn L. Ma	rtin Co
ค.พา nd 21	D 0	Be Co	17. Father's Name (First, Middle, Last)		Fac	Raging	Engineer 18. Mother's Nam	e (First, Middle, N		iem w.
	should be ad Mental marked c	To B	William Henry Riffle	9			Anna Es	ther Zie	gler	
Aillian	2 should and Men ie marke reumatic	·	19a. Informant's Name/Relationship (Type, P)	-	eet and Number or Rur			
	Tea The		Eleanor S. Riffle 20a. Method of Disposition	(wife)		12 Ceda sition (Name of	r Lane - K		e, Marylan 20c. Location - City or	
μõ	Pages nent of I int: if it		1 ☐ Burial 2X Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	al from State	emetery, crer	matory or other	place)			, Maryland
√ Baltimore,	permit. Pages Department of Important: if it eny injury or o		21. Signature of Funeral Service Licensee	Me						l Home, P.A.
ä	a o m a g		1 C. S. J.	saln			air Road -			
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can	ns that caused the death use on each line.	. Do not ent	er the mode of	dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Advanc	ed	Deme	nta			Oriset and Death
	Examiner			Due to (or as a consequ	ience of):	+ 1	00			
ļ.		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience of):) 111				
Ly	ecuted and transi	Examiner	that initiated events c							
760,	le be executed ysicien and e burial-transit	cal E	rosumy in doubly cast	Due to (or as a consequ	ience ot):					
	a × 6		d							
×	eath certificat attending phy I for use as th	M/UR	23b. was decedent pregnant	yes, outcome of pregna □Live birth 2 □ Fetal		∃Ectopic pregna	IFOV.		23d. Date of de	livery
P.O. Box 68	it the deat by the att tached for	by Physician/Med	1 Ves 2 No	□Pregnant at time of de □Unknown		Other (specify			Month	Day Year
	that the	Phy	Part II. Other significant conditions contribut	ing to death but not resu	ılting in the u	nderivina cause	given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
rds,	quires n sign uld be		Parkinson	Disea	sp.			1		robably 4 Unknown
Ō	law requir as been s 2 should	Completed	Joseph John John John John John John John Joh	<i>z z</i> , = c c c				24a. Was ar	n 24b. Were au	utopsy findings available
R	The l	Com						autopsy perform 1 ☐ Yes 2	y prior to ned? death? □ Yes	completion of cause of
Vita	iclan: T	Be	25. Was case referred to medical examiner?	a le				h (Check only one	9)	
of	ding Physician: After this certific funeral director,	. To	1 Yes 2 No Hospit	a. 1 ☐ Inpatient 2 ☐ I a. Date of Injury	ER/Outpatien 28b. Time of	IT 3L DOA			nce 6 Other (Spe	cify)
io	nding ath. r: After e funer	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		njury at Work? I ☐ Yes 2 ☐ No			
Division of Vital Records,	r Attendi	Certification:	3 Suicide 6 Could not be determined 28	e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, offi	СӨ	28f. Location (Str City or Town	reet and Number or Ri	ural Route Number,
۵	To the Hospitel or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 Ortifying Physician	. To she had a facilities						
	• Hos 24 ho • Fun	Medical	(Check only 2 Medical Examiner: (To the best of my known the basis of examinated manner stated. 	ion and/or in	vestigation, in m	e time, date and place, ny opinion, death occur	and due to the ca red at the time, da	iuse(s) and manner as ite and place, and due	s stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1.40		29c. Lic	ense number	29	d. Date signed (Mont	h, Day, Year)
			Manul	YV	MD)	19533	A	turnst:	28,2007
	148		30. Name and address of person who complete	ed cause of death (Item	23а) (Туре,	Print &	aw Stiv	reet -		1 200)
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	1 .0	Abendo	een, s	langla m	- 00
	Registr		AUG 3 1 20	17 December	J. J	GOOMS!			/	

			For State Registrar	State of Marylar		artment of H <i>rtificate of I</i>				27958
	Physici		Decedent's Name (First, Middle, Last MARGARET	•	ROHLED	ER		2. Date of Death Month AUGUST	Day Year 28, 200	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, given RIVERVIEW NURS		Y	4b. City, Town, or ESS	Location of Death	AUGUDI	4c. County of De	
	Funeral Director		214-24-1500	7. Age (in yrs		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 5 — 1 — 1 9 2	(29) 9. Bi	rthplace (State or Foreign
	Maryland a-f show fied at	tor	Usual Residence of Decedent 10a. State 10b. County BALT	EMORE 10c. Ci	ty, Town or Lo	cation MIDDLE	RIVER			10d. Inside City Limits 1 □Yes 2 No
	ith with the 23a or 28a ust be not	Funeral Director	10e. Street and Number 201 MIDDLEWAY I	ROAD		10f. Zip Code	21220	10g	j. Citizen of What C	S.A.
900	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notifited at	Ş	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ፟፟X Widowed 4 ☐ Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi fYes, specify Cuba I∐Yes 2☐ X No	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W	
21215-0036	thin 72 h e. an "natu Medical	Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)	fucation ide completed) College (1-4or 5+)	I (Give)	OO NOT use retired,	luring most of workii)	ng 16	b. Kind of Business	s/Industry
7	be filed wil ntal Hygien ed other th event, the		1 0		ļ	HOMEMA		Print Middle Ad		N HOME
yland	ould be f Mental I arked of atic eve	To Be	MICHAEL	DREGER			18. Mother's Name		•	CLAWSKI)
, Mar	and 2 sho salth and n 27 is ma		19a. Informant's Name/Relationship (1 MICHAEL G. ROHI		19b. Mailin	g Address (Street a	and Number or Rura ARD ROAD		City or Town, State,	Zip Code) 20854
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	Removal from State //	Cemetery, crem CTRO CI		9-6-	07 C	C. Location - City of CATONSVI EDALE FOO DALE, MI	LLE, MD CERAL HOME
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		th. Do not ente	er the mode of dying		r respiratory arres		Approximate Interval Between Onset and Death
68760,	ificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b						
_		ian/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths?	23c. If yes, outcome pf pregnation	al déath 3□	Ectopic pregnancy			23d. Date of de	livery Day Year
P.O. Box	at the de by the a tached f	Physician/M	1 ☐ Yes 2 MI No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown		Other (specify)			Worter	Day rear
	The law requires that the death cert ite has been signed by the attending bage 2 should be detached for use a		Part II. Other significant conditions of	ontributing to death but not res	ulting in the un	derlying cause give	n in Part I.			o the cause of death? robably 4 Unknown
Vital Records,	i ician: The law r certificate has be rector, page 2 sh	Completed by			Production			24a. Was an autopsy performe 1∐ Yes 2 【	prior to	utopsy findings available completion of cause of
<u></u>	ysiciar s certif directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	FB/Outpatient		26. Place of Death		e 6 □Other (Spe	
Division or	nding Phy th. : After this funeral o	H 1	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at 2	8d. Describe how	injury occurred	ecity)
DIVIS	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director; p	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, stre	et, factory, office	2	8f. Location (Stree City or Town, S		ural Route Number,
	ne Hospit n 24 hour ne Funera pletely fille	edical (29a. Certifier (Check only one) 1 Certifying Phyone) 2 Medical Example 1	ysician: To the best of my kno liner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the tim estigation, in my op	e, date and place, a inion, death occurre	and due to the caused at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
)	To t To tl	Ž	29b. Signature and title of certifier	D.		29c. License	3875	4 0	S-28	th, Day, Year) - 2007.
	7		30. Name and address of person who o	completed cause of death (item	70°C	Print) BAS	TERN 1	SLVD	M.D- ?	2-12-21.
	Sta Registr	36	31. Date filed (Month, Day, Year) AUG 3 1 2007	2. Registrar's Signa	iture					
DILL	4H 17 Pov 1/20	0.4		Contract of the Contract of th	9					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fb 8870 8-31-07 vt
State of Maryland / Department of Health and Mental Hygiene 27959 Reg. No 2 0 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Roberts Month -acy 18:41 PM AUGUST 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balti more Johns City HO PKINS 5. Social Security Number 216–33–2346 If Under 1 Year If Under 3 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) yrs. last birthday) **Funeral** Min. 1 □ M 2 🕱 F 16 Director 8/06/1991 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits MD N/A BALTIMORE CITY 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 7 2405 BAKER STREET 21216 USA Funeral r than "natural", or Items : the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) STUDENT STUDENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be STACIA NELSON GEORGE A. ROBERTS 2 19a. Informant's Name/Relationship (Type. Print)
SONYA ROBERTS / GRANDMOTHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2405 BAKER STREET, BALTIMORE, MD 21216 permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any In|ury or other trau once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State KING MEMORIAL PARK 9/07/07 WINDSOR MILL, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility HOWETLL FUNERAL HOME 21. Signature of Funeral Service Licensee 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD 21207 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease or condition resulting in death) Renal **Physician** Acute 3 days /Medical Due to (or as a consequence of). Examiner 6 months Cell Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Distress Syndrome The law requires that the death certificate be executed Res Diratory physician and s the burial-trans Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 5 ☐ Other (specify) 9 Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 2 No 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Res - 000 30. Name and address of p eath (Item 23a) (Type, Print) Baltimore Carolyn 600 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG Registrar 2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month atricla Sessa 2 2007 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltmore Medical Cente Sex 1 M 2 F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Director 212-34-1244 1/17/1936 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 TXNo Director Middle River Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 611 Waterside Court 21220 S. A. death 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 X No þ Specify: 3 Widowed 4 □ Divorced White Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ Kenneth Walter John Roth Hazel Marie Knorr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Quick (Daughter) 611 Waterside Court Middle River, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Memorial Gardens 2007 Middle River, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA Sm 1407 Old Eastern Avenue Essex, Maryland 21221 what lin 23a. Part1, Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed Due to (or as a consequence of) -burial-P.O. Box 68760, attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year signed by the at d be detached for 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 🔲 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an page 2 s autopsy performed? ∕es 2 □ No certificate 1X Yes Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospira. Swithin 24 hours after death.

To the Funeral Director: After this commetely filled in by the funeral director. 1 Inpatient P 1 Yes 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐Homicide 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of teath (Item 23a) (Type, Print) 4940 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 27961 State of Maryland / Department of Health and Mental Hygien? [] [] 7 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year SIVERD HAROLD 19 2007 /Medical 10:45 AM 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11715 Reynolds Road Kingsville, Maryland
If Under 1 Year | If Under 24 Hrs. | 8 Date of Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 1**∑**M 2□F Hours Min. Yrs. Director 87 176-16-0159 01/30/1920 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 Is marked other than "netural", or items 23e or 28e-f show other traumatic event, the Medical Evant an inustice notified at Director 1 ☐ Yes 2 ☑ No MD Baltimore Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11715 Reynolds Road Funeral 21087 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 X No Be Completed by Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Machinist Machine Manufacturing 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hy ant: If item 27 Is marked oth 18. Mother's Name (First, Middle, Maiden Sumame) John Siverd Dulcie Burnhiemer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma B. Siverd (wife) 11715 Reynolds Road - Kingsville, Maryland 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. injury or ' 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdns.09/01/2007 Bel Air, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 as 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician a MALIGNANT FIBROUS HISTIOCYTOMA 1 years 9 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ARTERY 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 X No 1 Yes To the Hospitel or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director; 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral I 1) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State

AUNG

SGIN

29b. Signature and tille of certifier

MD

30. Name and a good of person who completed cause of death (Item 23a) Type, Print)

32. Registrar's Signature 136145-1

Hematologu

9103 FRANKUN SOUARE DRIVE \$2200; BALTIMORE, MD 21237

29c. License number

D-51555

29d. Dateysigned (Month, Day, Year)

2007

Registrar

Poscologist

21222

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Non Small cell

1 Yes 2 No

CHEF

20b. Place of Disposition (Name of cemetery, crematory or other to

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Metastatic

Due to (or as a consequence of)

METRÓ CRÉMATORY

13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

USA

18. Mother's Name (First, Middle, Maiden Surname)

BROWN

MILDRED

644 E. HARBORSIDE DRIVE, JOPPA

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

22. Name and Address of Facility CVACH / ROSEDALE FUNERAL 1211 CHESACO AVE BALTIMORE, MD 21237

8/29/07

14. Race - American Indian,

, MD 21085

Approximate Interval Between Onset and Death

lomonth

Black, White, etc.

Specify: WHITE

16b. Kind of Business/Industry

RESTAURANT

20c. Location - City or Town, State

BALTIMORE, MD

with the Maryland r 28a-f show notified at ns 23a or must be r death Pages 1 and 2 should be filed within 72 hours after nent of Heatth and Mental Hygiene. Interest if item 27 is marked other than "natural", or the ury or other traumatic event, the Medical Examine. Juty or other traumatic event, the Medical Examine. Baltimore, Maryland 21215-0036 Department of H Important: If ite any Injury or ott once. 1 - For State Registrar

10a. State

Director

Funeral

Completed by

Be

2

MD

11. Marital Status

12

20a. Method of Disposition

Immediate Cause (Final disease or condition resulting in death)

1 ☐ Never Married 2 ☐ Married

3 ☐ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

RICHARD K. SMITH

4 □ Donation 5 □ Other (Specify)

21. Signature of Euneral Service Licensee

19a. Informant's Name/Relationship (Type. Print)

7301 DUNWALL CT APT. A

15. Decedent's Education (Specify only highest grade completed)

TIFFANY SMITH / DAUGHTER

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:

College (1-4or 5+)

Physician

/Medical

Examiner

Funeral

Director

Physician /Medicai Examiner

The law requires that the death certificate be executed attending ph been signed by the should be detached Hospital or Attending Physician; ours after death.

Division or Vital Records, P.O. Box 68760,

Examiner	it my leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):				
dical Exa	resulting in death) Last	Due to (or as a consequence of):				
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		pic pregnancy er (specify)		23d. Date of deliv Month	very Day Year
	Part II. Other significant conditions of	contributing to death but not resulting in the underly	ring cause given in Part I.		o use contribute to t 2 ☐ No 3 ☐ Pro	the cause of death?
Completed by				24a. Was an autopsy performed?	prior to co death?	opsy findings available ompletion of cause of
To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	Other:	th (Check only one) ome 5 Residence		ify)
	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury n	28c. Injury at Work?	28d. Describe how in	jury occurred	
Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		actory, office	28f. Location (Street City or Town, Sta	and Number or Rui ate)	al Route Number,
Medical (29a. Certifier (Check only one)	, and due to the cause rred at the time, date a	(s) and manner as	stated. to the cause(s)		
M	29b. Signature and title pertifier	sailam N.D	29c. License number DASS30	Pmladelphia rd MD21237		
	5-SIVASAIL	completed cause of death (Item 23a) (Type, Print)	18114 Pml	adelph	ard M	1021237
e	31. Date filed (Month, Day, Year) AUG 3 1 20	l General Solding Control	,			
14						

Sta Registra

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	ryland / D	epartment of I Certificate of	Health and N <i>Death</i>	Mental Hy	giene 2007	27963
	Dh î -	37	1. Decedent's Name (First, Middle,	Last)				2. Date of De	eath _	3. Time of Death
	Physici /Medi		Ronald Denni	s Shorts				August	27 2007	4:45 P M
	Examir	ner	4a. Facility Name (If not institution,	give street and number)		4b. City, Town,	or Location of Death		4c. County of Deat	h
			Bowie Health C		// / / / / / / / / / / / / / / / / / / /		wie		Prince G	
-175a	Funeral Director		5. Social Security Number 179–32–7129 Usual Residence of Decedent	1XM 2□ E	(In yrs. last birth	day) If Under 1 Year Months Days		8. Date of Bir (Month, Da June 2	9. Birti 29, 1943 Peni	nplace (State or Foreign untry) nsylvania
	land ow at		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Mary I-f sh fied	tor	MD Prince	George's	F	Bowie				1 XYes 2 ☐ No
	or 28a	Director	10e. Street and Number	3		10f. Zip Code			10g. Citizen of What Cor	untry?
	23a c	ral	_ 16000 Audubon	Lane		2	0716		USA	
	tems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Decedent of H	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No	14. Race - Amer Black, White	
36	s afte	by F	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Voc Givo	1	1 ☐ Yes 2 No		, , , , ,	C!	
5-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at		15. Decedent's	Year or Dates: 1		ecedent's Usual Occup	nation		WIT	
2	in 'na In 'na Medio	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)	(Give kind of work done ife. DO NOT use retire	during most of work d)	ring	16b. Kind of Business/I	naustry
7	d with giene ar tha the I	E O	Lienteritary/Secondary (0-12)	College (1-4or 5+		ogram Mana	ger		Sperry Unis	sys Corp.
and	be file tal Hy d oth	Be	17. Father's Name (First, Middle, L.	ast)			18. Mother's Name	e (First, Middle,	, Maiden Surname)	
Marylal	Men Men Marke	ို	Ted Shorts				Imagene	Wilson		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inmportant: If tiem 27 is marked other than "natural;" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship	,				_	er, City or Town, State, Z	ip Code)
บ์	1 and Healt em 2		Kathryn Shorts , 20a. Method of Disposition	spouse		100 Audubon		owie, M		0.1
allillo	ages ant of t: If it		1 ☐ Burial 2 X Cremation 3			hisposition (Name of crematory or other place	1	Date	20c. Location - City or 1	
	nit. Fartme		4 □ Donation 5 □ Other (Special Signature of Function 1)		Metropo	olitan Crem 22. Name and Addre		-11 D	Alexandria	a, VA.
Ď	permi Depa Impor any ir	1 12	122	X		6512 NW C			eral ноme e, MD. 207	715
9	4-1		23a. Part1. Enter the disease, or or shock, or heart failure. List or	implications that caused the	he death. Do no					Approximate Interval Between
	Physician	i	Immediate Cause (Final disease or condition	カンカナー						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of	J.	0,000	11/ 41/	CIIVA	
	Lammer	Jer	Sequentially list conditions,	b. Cor	consequence of	arter	cardial y des	eec		
7	ted nsit	Examiner	ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of	: 				
-	execunate and al-train	xar	that initiated events resulting in death) Last		consequence of	511	0/50			
Š	icate be executed physician and s the burial-transit	edical		d						
9	res that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	/ledi	JE EE MALE							
Š	th ce tendii	an/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf 1□Live birth 2	pregnancy	3 ☐ Ectopic pregnancy	,		23d. Date of deliv	ery
	the at	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at ti 9□Unknown		5 ☐ Other (specify) _			Month	Day Year
The low marries that the	hat the	Ph	Part II. Other significant condition	s contributing to death but	not resulting in the	Lo underlying course give	on in Doub!	OOo Did to		
		d b	The state of the s	o contributing to doubt but	not resulting in a	ie underlying cause giv	en in raiti.		obacco use contribute to t Yes 2 □ No 3 □ Pro	bably 4 Whiknown
		ete								
		Certification: To Be Completed						24a. Was autop	an 24b. Were auto prior to co rmed? death?	opsy findings available ompletion of cause of
	an: Taricat tificat tor, pa		25. Was case referred to medical	1			26 Plans of Dooth	1□ Yes	2 No 1 □Yes	2□ No
	ysici iis cer direct		examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient	2 X ER/Outpa	atient 3 DOA Othe	_26. Place of Death er: 4 □ Nursing Hor		<i>ne)</i> dence 6	6.0
)	ng Ph fter th neral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	28b. Tin	e of 28c. Injur			now injury occurred	197
	tendii eath. or: A		2 ☐ Accident investigat	ion	,		Yes 2 □ No			
	or At fiter d Direct in by	į	3 Suicide 6 Could not 4 Homicide determine		- At home, farm (Specify)	, street, factory, office	2	28f. Location (S City or Tow	Street and Number or Run vn, State)	al Route Number,
	purs a ceral I		29a. Certifier 1 Certifying	Physician: To the best of	my knowledge s	noth consumed at the time				(1)
:	24 hc 24 hc e Fun letely	Medical	(Check only 2 Medical Ex	Physician: To the best of aminer: On the basis of eand manner state	xamination and/	eath occurred at the tire or investigation, in my o	ne, date and place, a pinion, death occurr	and due to the deduction and due to the due to the deduction and due to the	cause(s) and manner as s date and place, and due t	stated. o the cause(s)
1	within To the complet	Me	29b. Signature and title of certifier	2		29c. License	e number		29d. Date signed (Month,	Day, Year)
ĺ	111		1 Then	nas , Co	MD	7 7	2/1/		P/29/20	v 7
1	つず、		30. Name and address of person wh	o completed cause of dear	th (Item 23a) (Ty	pe, Print)	- ' '		1: 27/20	1
(,		Thomas Y. Ko, I		Good Luc		ite #302	Lanha	m, MD. 2070	06
	Stat Registra		31. Date filed (Month, Day, Year)	2007 32. Registrar's	s Signature	Sparke				
T	riegistia	"	110002	No. of the second	4					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Rev. Dr. Paul H. Smith 11:00 P M /Medical August 29, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson 8. Date of Birth (Month, Day, Yes Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Year) Hours Min. 1**X** M 2□ F 217-36-4723 Director 1913 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County show 10d. Inside City Limits item 27 Is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director Md. Baltimore Baltimore 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9140 Satyr Hill Rd. 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **N**No 1 ☐ Yes 2 ☒ No Specify: Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Saltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Minister Church 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental R. Mervin V. Smith Mary E. Heiges 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trae Mrs. Suzanne Rowe/ Daughter 9149 Satyr Hill Rd. Baltimore, Md. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) John Lutheran Cem. 9-4-07 Baltimore, Md. ^{22. Name and Address of Facility} Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CVA **Physician** EMBOLIL WITH INFARCTION disease or condition resulting in death) 7 DAYS /Medical Due to (or as a consequence of): Examiner RESPIRATORY HYPER CARBIL HOURS Sequential list conditions Examiner rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): 1 YEAR that the death certificate be executed ATRIAL physician and is the burial-trans FIBRILLATION resulting in death) Last Due to (or as a consequence of): Physician/Medical as attending | for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð The law requires 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ◯ No autopsy page certificate 1□ Yes 2No : After this certification : 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 npatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

State Registrar

CHAN 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 NORTH CHARLES

STREET

29c, License number

253430

SUITE 4890 BALTIMORE MARYLAND

AUGUST 30

2007

29d. Date signed (Month, Day, Year)

32. Registrar's Signature

MO

harles	Gordon	Stewart
		1- For

2007 2796	, c , c , j o	- 1 - 0	2796	,	90	-
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	1- For State Certificate of Death Reg. No.
Physician/ ledical Examine	1. Decedent's Name (First, Middle, Last) Charles G. Stewart 2. Date of Death Month Day Year August 23, 2007 1951 hrs
/	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8526 Chestnut Oak Road Parkville Baltimore County
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Extraor)
Director	214-76-7188 1 XM 2 F 49 Yrs. Months Days Hours Min. Jan. 24,1958 Country) Maryland
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
*	Maryland Baltimore Parkville
the Maryland a or 28a-f show tiffed at once. Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
th the Maryland 23a or 28a-f sho notified at once.	8526 Chestnut Oak Road 21234 U.S.A.
leath with r items 23 nust be no	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
fler des	3 Widowed 4 Divorced If Yes 2 X No 1 Yes 2 X No specify: Specify: White
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shratic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
within 72 hc spiene. Medical Exponential	Elementary/Secondary (0-12) College (1-4 or 5+) Auto Adjustment Auto Adjustment Industry
215-0036 be filed within 7 mtal Hygiene. rked other than ent, the Medica	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
21215-0 uld be filed v Mental Hygi marked oth	Alexander George Stewart Betty Ann Hearn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MD 21 dd 2 should 1 lth and Me m 27 is ma aumatic ev	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2804 Erie Avenue Baltimore, Maryland 21234
Z da da da Z	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
MOr Pages ent of int: If	Hilltop Service Corp. 8-29-2007 Towson Maryland
Baltimore, permit, Pages I at Department of He Important: If ite injury or other to	21. Sharm une of Facility Ruck Towson Funeral Home, Inc.
Physician	233 Part Enter the disease or domalications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, shock, or heart Approximate Interval
/Medical	failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease a. Atherosclerotic Cardiovascular Disease
taminer	or condition resulting in death) Due to (or as a consequence of):
1	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
ed ted Transit	C. (Disease or injury that initiated constitution of the control o
	events resulting in death) Last Due to (or as a consequence or).
ficate be executed g physician and the burial - transit	UNPENDED AMENDED
Box 68760, death certificate be execu he attending physician and defor use as the burial - tra	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year
Box 68 he death certificate attending red for use a	past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown a Unknown
D. Box 66 the death cert by the attendir ached for use a	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
ires that the signed by lbe detach	Chronic alcohol abuse 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown
ords,	24a. Was an autopsy autopsy findings available prior to completion of cause of
Records, I The law requires ficate has been signage 2 should be	performed? death? 1 Yes 2 No 1 Yes 2 No
Vital Rec ysician: The l his certificate director, page	25. Was case referred to medical examiner? Hospital: The second of t
ing Physical directed	1 V Yes 2 No 128a Date of Injury 2 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred
on cending sath. or: Af	1 Natural 5 Pending (Month, Day, Year) 1 Yes 2 No
Division of Vital Records, spital or Attending Physician: The law requir neral Director: After this certificate has been setfilled in by the funeral director, page 2 should be certification:	2 Accident and Number of Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)
iner hou	
To the Ho within 24 1 To the Fu completely	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	O.C.M.E. August 24, 2007
	30. Name and address of person who completed cause of death (Item 23a)
V	Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature
Star Registra	
DHMH 17 Rev 1/200	ORIGINAL

		- For State Registrar 1. Decedant's Name (First Middle	Last)	/ Departm Certific	cate of Death		Reg.	No. 201	37 279 3. Time of Death
hysicia Examin	ij.					2. Date of Death Month Day Year August 22, 2007 3. Time of Death 1720 hrs			
LXummi		ERNEST GORDON T 4a. Facility Name (if not institution		·)	4b. City, Tow	n, or Location of Death	August 22, 2	4c. County of Deat	h
		2517 Sycamore Avenu	e	,	Sparrow	s Point		Baltimore Co	unty
uneral		5. Social Security Number	6. Sex 7. As	ge (In yrs. last bi			8. Date of Birth (MM/DD/YYYY) 9. Bi Forei	
rector	-	213-36-6900 Usual Residence of Decedent	1 X M 2 F	67	Yrs. Months	Days Hours Min.	APRIL 5		ountry) NC
'any		10a. State 10b. County		10c. City, Tow	n or Location				10d. Inside City Limits
28a-f show 1 at once.	٥	MD BALTIN	MORE	SPAR	ROWS POINT				1 X Yes 2 No
al", or items 23a or 28a-f sho ner must be notified at once.	Director	10e. Street and Number			10f. Zip Co	de	109	Citizen of What Cou	untry?
23a o notifi		2517 SYCAMORE A			2121	9 of Hispanic Origin? (Sp	neify Van ar Na	USA	rican Indian, Black,
tems st be	Funeral	11. Marital Status 1 Never Married 2 Ma	rried Armed Forces	?		uban, Mexican, Puerto		White, etc.	ilicali lilulali, black,
or i		3 X Widowed 4 Divo	1 Yes 2 proced If Yes, Give Year	X No	1 Yes 2 X	No specify:		Specify: BI	ACK
= =	è.	15. Decedent's Education (Spec	or Dates:	mpleted) 16a	a. Decedent's Usual Occ	cupation (Give kind of w		6b. Kind of Business	Industry
giene. ner than "natui Medical Exam	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)	during most of working	g life. DO NOT use retir	ed)		
tygiene. other than ' the Medical	ğ		+1		BRICK LAYE			CONSTRUC	TION
Hygi d oth		17. Father's Name (First, Middle,	Last)			18.Mother's Name	`	iden Surname)	
Mental Hygien marked other c event, the M	o Be	JUNE H. TYSON 19a. Informant's Name/Relationsh	sin /Type Print \	T1	9b. Mailing Address (ESTHER I	SURRELL	er City or Town Stat	te Zin Code)
h and N 27 is n	Ĕ	GILLIAM TUCKER				ORE AVE., I			
t of Health and I frien 27 is ather traumatic		20a. Method of Disposition	DRUITER		e of Disposition (Name		Date	20c. Location - City of 712 O DON	
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Department o Important: injury or oth	- +	4 Donation 5 Other Sp. 21. Signature of Fune Sprice I			MT. CARMEL	dress of Facility WES	29/200/ [1 21 EV CHAN	BALTIMORE,	MD 21224
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sician	+	23a. Part I. Enter the disease, or	complications that cause	d the death. Do	not enter the mode of d	ying, such as cardiac or	respiratory arres	t, shock, or heart	Approximate Intervi
edical	ļ	failure. List only one cause	on each i fne. a. Atherosclerotic	Cardiovaso	ular Disease				Between Onset and Death
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ath. or: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transit.	To Be Completed by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unk Part II. Other significant conditiant Chronic alcoholiant Chronic alcoholiant Py Yes 2 No 27. Manner of Death 1 Yes 2 No Pendical Pendical Examiner? 1 Yes 2 No Pendical Pendical Examiner? 1 Yes 2 No Pendical Pendical Examiner?	Due to (or as a cond. AMENDED PETM 23c. If yes, outcome 1 Live birth 4 Pregnant a g Unknown ons contributing to deal SIII Hospital: 1 Inpat 28a. Date of Ir (Month, Day ling)	sequence of): 1E. g875. The g875 one of pregnance at time of death at the but not result time of the sequenc	26. Petal death The first of t	use given in Part I. Place of Death (Check	23e. Did tob 1 Yes 24a. Was ar autops: perform 1 Yes 2 only one) g Home 5 F	Month acco use contribute to the contribute to	Day Year to the cause of death? robably 4 Unknown autopsy findings availab o completion of cause of? Yes 2 No
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Registrar
DHMH 17 Rev 1/2001

State

Malcalm dum,

cause of death (Item 23a) (Type, Print)

07-06683

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 27968

JUI	1- For State 1- For State Registrar 1- For State 1- Fo							
	Physicia		tegistrar 1. Decedent's Name (First, Middle,Last)		Date of Death Month Da	v Year	Time of Death 1540 hrs	
ď	Exami	ner	Victor A. Terziu		August 28, 20	007	10401113	
			4a. Facility Name (if not institution, give street and number) 4b. City	ty, Town, or Location of D	eath	4c. County of Death		
			1128 Hewitt Way	Itimore			1 (0)-1-1-1	
	Funeral		5. Social Security Number 6. Sex	Under 1 Year If Under 2	4Hrs. 8. Date of Birth (N	MM/DD/YYYY) 9. Birthp Foreign	ì	
	Director	- 1	213-47-5397 1X M 2 F 44 Yrs. MO	onths Days Hours	Sept. 6,	,1962 Coun	^{try)} Maryland	
		- 1	Usual Residence of Decedent				orton star form the fact	
	any	1	10a. State 10b. County 10c. City, Town or Location				0d. Inside City Limits 1 X Yes 2 No	
	ž ,		Mryland N/A Ba	altimore				
-	Aaryland 28a-f show 1 at ouce.	용		. Zip Code	10g.	Citizen of What Countr	y?	
1	h the Maryla 3a or 28a-f	Director	1120 Harritt May	21205		U. S. A.		
5	ith th 23a noti		1128 Hewitt Way 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dec	cedent of Hispanic Origin	? (Specify Yes or No-	14. Race - America	n Indian, Black,	
	ath w	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, sp	pecify Cuban, Mexican, P	uerto Rican, etc.)	White, etc.		
	er de			2 X No specify:			ite	
	rs aft ural'	<u>5</u>	Lor Dates: 16a Decedent's Us	sual Occupation (Give kin		6b. Kind of Business/Inc	dustry	
	2 hou "nat	ted	Elementary/Secondary (0-12) College (1-4 or 5+)	f working life. DO NOT us	se retired)	. 16		
	36 hin 7 e. than	g	12 Tru	uck Driver		Transpor	tation	
	-00 d with	Completed	17. Father's Name (First, Middle, Last)		Name (First, Middle, Ma			
	21215-0036 Juld be filed within 7/ Mental Hygiene. marked other than c event, the Medical	Be (Victor L. Terziu	Ве	etty Calend	ine		
	imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland noet of Health and Mental Hyginst House of Health and Mental Hyginst House 123 a or 28a-f she note. If them 27 is marked other than "natural", or items 23a or 28a-f she or other transmatic event, the Medical Examiner must be notified at once	0	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Add	dress (Street and Number				
	MD id 2 shot alth and m 27 is an anatic	•	Victor L. Terziu (Father) 807 Rol	bert Dean Di	rive, Downi	ngton,PA。 20c. Location - City or T	19335	
	ore, MC is 1 and 2 st of Health ar If item 27 her trauma		20a. Method of Disposition 20b. Place of Disposition crematory or other p	place)				
	NOT ages of the of	1	1 Burial 2 X Cremation 3 Removal from State crematory or other p	matory (08/31/2007	Baltimore,	Maryland	
	Baltimore, permit. Pages I an Department of Her Important: If ite injury or other tr		21 Signature of Funeral Service Licensee 22. Name	and Address of Facility	Schimunek F	uneral Home	e Inc.	
	Ba perm perm Depa Imp		R C. 10000 9705	Belair Roa	d, Nottingh	a, Marylan	d 21236	
	ysician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the m	node of dying, such as car	rdiac or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and	
J	ledical		failure. List only one cause on each line. Immediate Cause (Final disease a. Narcotic intoxication				Death	
	xaminerے		or condition resulting in death) Due to (or as a consequence of):					
			Sequentially list conditions, b					
		Examiner						
_			(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
	ted f msit	Ìй						
	760, cate be executed physician and the burial - transit	Medical	X UNPENDED AMENDED 27,28a-f, perME,g871	9/11/07 TT				
	60, ate be oblysicial to burile	led	##Z0a,27,20a-1, Detrib,g071			23d. Date of delivery		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and commelency filled in white funeral director, page 2 should be detached for use as the burial - trans		1 5			pregnancy	Month [Day Year	
		sician	past 12 months? 4 Pregnant at time of death 5 Other 1 Yes 2 No 9 Unknown	(Specify)				
		Phys	Part II. Other significant conditions contributing to death but not resulting in the under	eriving cause given in Pa	rt I. 23e. Did tol	bacco use contribute to	the cause of death?	
		A		Citying daddo green in the	1 Yes	2 No 3 Pro	bably 4 🗸 Unknown	
		1 2	(t)		24a. Was a	an 24b. Were au	utopsy findings available	
	ords w requas been				autops perfor	sy prior to	completion of cause of	
	BCO ne law te has	Completed			1 Yes 2		es 2 No	
	n: The			26.Place of Death				
	/ita sicial is cer	ď	Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other		Residence 6 Othe	er: Scene	
	FPhy ter th	-	27 Manner of Death 28a, Date of Injury 28b, Time of Injury			now injury occurred		
	nding Fr. At] [1 Natural 5 Pending Fnd 8/28/2007 Fnd 2:30	pm 1 Yes 2 X	-			
	Sior Attend or death rector:		2 Accident Investigation FTIC O/ 25/ 2607 FTIC 2.55 3 Suicide 6 X Could not be	factory, office building, et	tc. 28f. Location (S or Town, S	Street and Number or R	ural Route Number, City	
	Div	Cortification.	3 Suicide 6 X Could not be determined (Specify) found at residence	ce	1128 Hev	<u>vitt Way Balti</u>		
	Hospital 24 hours Funeral	~ -		d at the time date and his	ace, and due to the caus	se(s) and manner as sta	ited.	
	To the F within 24	Modical	Certifying Physician: To the best of my knowledge, death occurred (Check only one) Wedical Examiner: On the basis of examination and/or investigation and manner stated.	n, in my opinion, death of	courred at the time, cate	and place, and due to		
	5. ½ €	3 2	29b. Signature and title of certifier	29c. License number	•	29d. Date signed (M	-	
1			him him had	O.C.M.E.		August 29, 200	/	
	7		30. Name and address of person who completed cause of death (Item 23a)					
7~	ic pund	2	Ling Li, MD Assistant Medical Examiner 111 Penn Street,	, Baltimore, MD 212	201			
	LVVIO	Stat	31. Date filed (Month, Day, Year) 32. Registrar's Signature	· N ·				
		Star	0110 0 4 2007 1884 16 188	23421				

ORIGINAL

			For State Registrar	State of N	/aryland / Dep <i>Ce</i>	artment of		nd Mental H		007	279	169
~	Physic	ian	1. Decedent's Name (First, Middl	e, Last) AS JAMES TH	ORECON			2. Date of D Month AU(eath Day	200 ^{Year}	3. Time of 1	
	/Medi Examii		4a. Facility Name (If not institution			4b. City, Town	, or Location of			ounty of Death	10.20	A W
			NATIONAL NAVA				THESDA	Alle Lee		IONTGOM		
ь	Funeral Director		5. Social Security Number N/A	6. Sex 7. A	Age (In yrs. last birthday Yrs.	Months Day		Min. (Month, L	orth Day, <i>Year)</i> 23, 201	Coui	place <i>(State or</i> ntry) land	· Foreign
	D.		Usual Residence of Decedent					Aug.	23, 20			
	anylar show	<u>_</u>	10a. State 10b. County		10c. City, Town or L	ocation				1	10d. Inside City 1√2 Yes	
	the M 28a-f notifie	recto	MD Prince 10e. Street and Number	e George's	Laurel	10f. Zip Code			10a Citizer	of What Cour		
	3a or	Ö		lge Circle		101. Zip 0000	2070	17	rog. Oluzer	USA	nty:	
	ems 2	Funeral Director	11. Marital Status	12. Was Deceder	nt Ever in U.S. 13.	Was Decedent o		in? (Specify Yes or N Puerto Rican, etc.)	10- 14.	Race - Americ		
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fu	1 X Never Married 2 Marri	ied 1 Tes 2 If Yes, Give	₫ No			Columbian		Black, White, pecify: Wh	ite	
21215-0036	hour hurai	ed b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates		edent's Usual Occ				of Business/In		
215	hin 72 e. an "na Me ik	Completed		st grade completed) College (1-4o	(Give	e kind of work dor DO NOT use reti	ne durina most i	of working				
	ed withi ygiene. er thar t, the M	Com	Infant		′	nfant				nfant	<u>-</u>	
Maryland	12 should be filed w n and Mental Hygie is marked other ti raumatic event, th	Be	17. Father's Name (First, Middle,	•				's Name (First, Middi		,		
Ž	should nd Mel marke matic	은	Brian James 19a. Informant's Name/Relations		19b Mail	ing Address (Stre		y Christi			Code)	
	1 and 2 s Health ar em 27 is		Brian James Th	, , , ,				rcle, Lau			•	
J.	ss 1 a of Hea item		20a. Method of Disposition		20b. Place of Disp		- ;	Date		ion - City or To	·	
ij	Pagment ment: If ant: If ury o		1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (S		West Aru		,	/31/2007		ton, MD		
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr		21. Signature of Funeral Service	Licensee	/ 2407700			Donaldso		ral Hom	e, P.A	
			23a. Part1. Inter the disease, or shock, or heart failure. List	complications that caus				enue, Laur		20707	Approximate Interval Betw	
A 100 A 100	Physician /Medical Examiner		Immediate Chie (Final disease or condition resulting in death)	a. EXTR Due to (or a	EME PREMATU as a consequence of):						Onset and D	eath
8760,	icate be executed physician and s the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Under, in Cause Unsease or injury that initiated events resulting in death) Last	с	as a consequence of):							
P.O. Box 68	t the death certif by the attending ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3 at time of death 5	⊒Ectopic pregnar ⊒ Other (specify)			23d	. Date of delive	•	'ear
	w requires that been signed should be det		Part II. Other significant condition	ons contributing to death	but not resulting in the ι	inderlying cause (given in Part I.			contribute to t No 3 ☐ Prot		
Vital Records,		Completed by						24a. Wa aut per 1 Yes	formed?	24b. Were auto prior to co death? 1 ∐Yes	psy findings a mpletion of car	vailable use of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Magnital				of Death (Check only	one)			
0	Phys ral di	은	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 X Inpa		OLI DOA		sing Home 5 Re			5y)	
O	Attending Phyrdeath. ector: After thi by the funeral of	tion	1 XNatural 5 Pendin 2 Accident investig	g (Month, E	Day Year) Injury	W	ork? □Yes 2□N		e now injury o	ccurred		
Division	- t t -	Certification:	3 Suicide 6 Could determ	not be ined 28e. Place of i building,	njury - At home, farm, st etc. <i>(Specify)</i>	reet, factory, offic	е	28f. Location City or T	(Street and Nown, State)	lumber or Rura	al Route Numb	oer,
	To the Hospitai or within 24 hours afte To the Funerai Dir. completely filled in I	ledical (29a. Certifier 1 Certifyir (Check only one)	g Physician: To the bes Examiner: On the basis and manner	et of my knowledge, dea of examination and/or in stated.	th occurred at the ovestigation, in m	time, date and y opinion, death	d place, and due to the h occurred at the time	e cause(s) an e, date and pl	d manner as s ace, and due to	tated. o the cause(s)	
	To the To the Complex	Ň	29b. Signature and title of certifie	(/ (),	140	29c. Lice	nse number		/mg	igned (Month,		
	4		PUTUSA	J LIB	rid (III)		065419		081	27, 2	007	
, 191	2 1		30. Name and address of person AGNES SIEROCKA		death (Item 23a) (Type, USA	ŕ		AL NAVAL M			R	
	Sta	ate	31. Date filed (Month, Day, Year)		trar's Signature	All D	BETHESI	DA_MD_2088	9-5600			
	Registr		AUG 3 1	2007	J JS 18	- Comment						

			1 - State o	f Maryland	d / Depa <i>Cei</i>	artment of F rtificate of I	lealth and M Death	ental Hyوا ا	giene Reg. No. 2	007	27970
	Physici	an	1. Decedent's Name (First, Middle, Last) Beulah L.			ompson		Date of Dea Month	ath Day		3. Time of Death 5:50 P M
	/Medic		4a. Facility Name (If not institution, give street and nur	nber)	111	-	Location of Death	August		unty of Death	3:30 P ···
Q.	Examin	er	Gilchrist Center			Tow			Ва	ltimo	re
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 ₹ F	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day June 4	h v. Year)	9. Birth	place (State or Foreign
	р ,		Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Lo	cation		-		1.	10d. Inside City Limits
	Maryla f shov ed at	or	Maryland Baltimore		Dunda						1 □Yes 2X1No
	r 28a-	irect	10e. Street and Number		Dariou	10f. Zip Code			10g. Citizen	of What Cou	ntry?
	th with	ai D	9 Winona Avenue			2	21222			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funera! Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Deccarried Formula of the property of the	2 1 No /e		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes X No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, ec <i>ify: W</i> hi	etc.
2-00	72 hou natura ilical E	eted I	15, Decedent's Education (Specify only highest grade completed)	Ţ	(Give	dent's Usual Occup	during most of work	ina I	16b. Kind	of Business/In	dustry
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Balti	permit. Departr Importa any Inju		21. Signature of Funeral Service Licensee	mell	LU 7	110 Solle	ss of Facility uneral Ho ers Point	Road, I	Dundal	k,P.A. k,Md.	21222
			23a. Part . Enter the disease, or complications that of shock, or heart failure. List only one cause on a immediate Cause (Final	aused the death each line.	. Do not ent			or respiratory a	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition	ر کا کا کا (or as a consequ	ence of):	7 718	rosis			-	year
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ó,	ficate be executed physician and s the burial-transit	Exa		(or as a consequ	ence of):						
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Vital Records, P.	uires that t signed by Id be detac	by	Part II. Other significant conditions contributing to de				en in Part I.		obacco use	_	he cause of death?
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	12		W. A. Riley GAM	€ 670	IN.	Charle	. St. B	alto.	and	2150	15
	Sta Registi		31. Date filed (Month, Day, Year) AUG 3 1 2007	gistrar's Signat	J. A	judi					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 8 **Physician** 29 2007 imo. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Gilchrist lowsor paltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, **Funeral** Days Year) 1 M 2 M F 82 219-16-982 -24-1924 Baltimore Md Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 ☐ Yes 2 No Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or items 23a or Examiner must be r USA 21234 2515 endore **Funeral** 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 "natural", or 1 ☐ Yes 26 No Specify: þ white 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Insurance Keeper 17. Father's Name (First, Middle, Last) . 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill f Health and Mental H ttem 27 is marked oth Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Joseph Vardy Road kville Md 2515 Wendover husbanc Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place)

Baltimore National
Cometery 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 9-4-2007 Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Surs-Parkville 18800 Harford Rood Parkville Md 21234 remnett 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0 f Complications **Physician** weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ed by the a detached f P.O. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause giv in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ₽ 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe certificate 2 No Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical exeminer?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: $_{4}$ Nursing Home $_{5}$ Residence $_{6}$ Other (Specify) $_{6}$ Other 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation June 24 2007 UNK AM 1 ☐ Yes 2 X No Fell 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide HOSPITAL OXER DR. TOU SON MD 7601 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

32. Registrar's Signature

AARON J. CHARCES, MD

31. Date filed (Month, Day, Year) AUG 3 1 2007 D 58303

N. Charles ST POWSUN MO 21204

29 200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Many and Peter Bart 6871 of Health awa Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8 Day Physician 30 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner STELLA MARIS BaltimoRE 1 IMONIUM If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 93 Yrs. Hours 1 □ M 2 🗗 F Balt. MARYLAND Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 No Baltmore TIMONIUM Director MARYIAND 10g. Citizen of What Country?

UNITED STATES

OF AMERICA 10f. Zip Code 10e. Street and Number 12. Was Decedent Ever in U.S.
Armed Forces?
1 | Yes 2 20 No
If Yes, Give
Year or Dates: 21093 "natural", or Items 23a 2300 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 1 No 3altimore, Maryland 21215-0036 þ 3 Midowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) SELF EmployED -lorist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GREELEY AUGUST 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARETTE AUE. 1311 lowson, MARY LAND 21286 DONNA)0UZIS Date 4 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1. Burial 2 □ Cremation 3 □ Removal from State 2007 KIDGE 4 ☐ Donation 5 ☐ Other (Specify) Baltmore MARYLAND Name and Address of Facility
CEFUL ACTERNATIVES FUNCASE & CREMATION CTE., P.A. 21. Signature of Juneral Service Licenses YORK ROAD TIMONIUM, MARYLAND 21093 Approximate Interval Between Onset and Death 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, sych as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each jury. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner bunal-transit Due to (or as a consequence of): Box 68760. attending physician pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month signed by the at d be detached for P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy dironic performed certificate 25. Was case referred to medical examiner?

1 Yes 2 16 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) WAGNER, 28d. Describe how injury occurred ne Hospital or Attending P n 24 hours fiter death. ne Funeral Director Affer t After t Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical praminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the I within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDDIE NAKHUDA, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM MD21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

AUG 3 1 2007

JOSEPHINE

			For State Registrar		State of	iviaryian	•	artment rtificate		eaith and Death	Mental F		ne. No. 20 0	7	27073)
140			1. Decedent's Name (First, Mid	dle, Last)							2. Date of Month	Death		ear	3. Time of Death	,
	Physicia /Medic	_	Elizabeth		Vi	rginia	ı	Wag	ama	n	Augus		9, 20	07	4:20P M	
	Examin		4a. Facility Name (If not institut	ion, give s	treet and num	nber)		1		Location of Deat	h		4c. County of I	Death		
		_	Joseph Richi			~ . <i>"</i>		If Under 1		imore If Under 24 Hrs	O Data of	Diste	N/A	District	(0)	
	Funeral Director	1	5. Social Security Number 205–09–9683	6. Sex 1□	M 2 X F	7. Age (In yrs. I	37 Yrs.		Days	Hours Min.	8. Date of (Month,	Day, Yei	ar)	Count	ace (State or Foreign ry) ylvania	
	land w t		Usual Residence of Decedent 10a. State 10b. Coun	ty		10c. City	, Town or Lo	cation			-	_		10	d. Inside City Limits	_
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	th the	irec	10e. Street and Number					10f. Zip				10g.	Citizen of Wha	t Count	ry?	
	th wit	la	8123 Bullneck	Road					1222				USA			
120p Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ M 3 ☐ Widowed 4 ☐ Divorce	arried	2. Was Dece Armed For 1 ☐ Yes If Yes, Giv Year or Da	2 ∑ No e	1	Was Decede If Yes, speci		spanic Origin? (S n, Mexican, Puer Specify:	Specity Yes or to Rican, etc.	No-	14. Race - Black, ' Specify:	White, e		
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。な/の) Baltimore,	Pages 1 ament of He ant: If iten ury or oth		20a. Method of Disposition 1 Burial 2 □ Crematio 4 □ Donation 5 □ Other	n 3 □Re	emoval from S	State Hol	Place of Dispo emetery, cre Lly Hi	osition (Nam matory or ot LL Men	e of herplace Ori a	. ,	ember 2007		. Location - Cit ddle Ri	•		
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	, Y		30. Name and address of pers	on who co	mpleted caus	e of death (Item	23a) (Type,	Print)	int.	170 w St	Balt	Mer	MD	21	20ì	
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Examir		WOR. 4a. Facility Name (If not institution UNIVERSITY	n, give street and number)	HOSPITAL	4b. City, Town, or BACTI	Location of Death		4c. County of D	
Funeral Director		5. Social Security Number 579–40–9997	6. Sex 7. Ag	ge (In yrs. last birthday 76 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day June 2	h, Year) 9,1931 N	Birthplace (State or Foreig Country) NEW YORK
Maryland -f show ied al	tor	Usual Residence of Decedent 10a. State 10b. County MD Princ	ce George's	10c. City, Town or I		· · · · · · · · · · · · · · · · · · ·			10d. Inside City Limit
with the e or 28e	Direc	10e. Street and Number		2011	10f. Zip Code	745		10g. Citizen of What	Country?
I and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I Health and Mental Hygiene. I the manual fee or 28e-f show item 27 is marked other then "naturel; or items 23e or 28e-f show other treumstic event, Ite Madical Examinational Examination	by Funeral Director	12724 Brunswid 11. Marital Status 1 Never Married 2 Mar 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces? 1 \(\superscript{Yes} \) 2 \(\superscript{X} \)		. Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 🂢 No)715 spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, W	merican Indian, hite, etc. Vhite
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Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ADVA Due to (or as Due to (or as MITA)	a consequence of): a consequence of): a consequence of): a consequence of): A	Arion	2CINOM/		rest,	Approximate Interval Between Onset and Death
leath certificate be executed attending physician and I for use as the burial-transit	edical	IF FEMALE:		VAR7 A	RIENY	Or St. A.	E	23d. Date of	falivery
res that the death cer igned by the attendir be detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			Month	Day Year
law requires that the death certif as been signed by the attending 2 should be detached for use a	ed by P		EDOPHARLY		underlying cause give	n in Part I.		/	to the cause of death? Probably 4 □Unknow
The ate h	Completed by	DIVENTICUI	c81 <u>{</u>				24a. Was a autop: perfor	sy prior t med2 death	autopsy findings available o completion of cause of ?
nding Physicien: The ath. Tr. After this certificate has funeral director, page	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Man -r of Death Natural 5 Pendin 2 Accident investig	Hospital: 1 Inpation 28a. Date of Inju (Month, Da	ry 28b. Time	of 28c. Injury Work	26. Place of Death T 4 □ Nursing Ho at ? Yes 2 □ No	me 5 Resid	ne) ence 6 □Other (S _i ow injury occurred	oecify)
To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	Certification:	3 Suicide 6 Could determ	ined 286. Place of In	ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (S City or Tow		Rural Route Number,
he Hospi in 24 hou he Funei pletely fil	edical	29a. Certifier 1 Certifyin (Check only one)	ig Physician: To the best Examiner: On the basis o and manner st	f examination and/or is	th occurred at the tim nvestigation, in my op	e, date and place, inion, death occurr	and due to the c red at the time, c	ause(s) and manner late and place, and d	as stated. lue to the cause(s)
Tot withi	Σ	29b. Signature and title of certifie	ATTE	ensing	29c. License うの。)	number 749	2	29d. Date signed (Mo	nnth, Day, Year)
V		30. Name and address of person	who completed cause of c			furt 3	BH, BALL	ilmone mo	21217
Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	mare				

Registrar DHMH 17 Rev 1/2001

State

MYRTLE

JARNER,

W. SPRINGS DRIVE ELLICOTT CITY 21043

KESIDENT

3160 D'

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 2007

31. Date filed (Month, Day, Year)

AUG 3

CHASHI DHARAN 3160 D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 27976 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARY ZIRK 5:40 PM AUGUST 2007 27 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE JOHNS HOPKINS BAYVEEW MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🗙 F Feb. 25, 1957 50 Maryland 215-56-5298 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X☐ No Joppa Maryland Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U. S. A. 21085 109 Fern Drive 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married 1 □ Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances G. Finnessy James Haught 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Steve R. Zirk (Husband) 109 Fern Drive, Joppa, Maryland 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/30/2007 | Baltimore, Maryland New Cathedral Cem. 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licensee 9705 Belair Road, Nottingham, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Muscardial 1 dex ٧n

Physician /Medical Examiner

Department of Important; If it any Injury or or once.

Physician

Examiner

Funeral

Director

r 28a-f show notified at

a or

"natural", or items 23a

Pages 1 and 2 should be filed within 72 honent of Health and Mental Hygiene.
snt: If item 27 is marked other than "natuury or other traumatic event, the Medical.

Director

Funeral

Completed by

Be

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

Examiner physician and s the burial-tran-Physician/Medical attending p signed by t 2 Be Completed certificate has birector, page 2 s Certification: To in 24 hours are:
the Funeral Director: Af

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, isolary to manifestate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Cerebro vacule accident Custo for as a consequence of): Lang Cancer Due to (or as a consequence of):	1 day
23b. was aecedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions con	c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown 23d. Date Mont	n Day Year
COPD	autopsy pri	Probably 4 Unknown Probably 4 Un
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	26. Place of Death (Check only one) pospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other	(Specify)
27. Manner of Death 1.★Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 ☐ Yes 2 ☐ No	
3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number City or Town, State)	

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 3

KEVIN

DHMH 17 Rev 1/2001

within 24

4940

29c. License number

D 0066 086

EASTERN AVENUE

29d. Date signed (Month, Day, Year)

AUGUST 27, 2007

BALTIMORE, MU 21224

and manner stated

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GROSZKOWSKI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2007 2. Date of Death
Month
Day 1. Decedent's Name (First, Middle, Last)

/Med	ical	MITCHAEL BRADY									AUGUSI				3:0/ A	
Exami	ner	4a. Facility Name (If not institution		4b. City, Town, or Location of Death						4c. County of Death						
		Gilchrist Cent	er @ GE				Towson						Baltimore			
Funeral		5. Social Security Number	6. Sex		(In yrs. la	st birthday	y) If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	of Birth 9. Birthplace (State or Fo			hplace (State or Foreign	
Director		212-52-9807	1 X M 2	JF	60	Yrs.	WOTHIS	Days	riouis		Feb. 3					
B		Usual Residence of Decedent														
/lan		10a. State 10b. County			10c. City,	Town or I	Location			10d. Inside City Limits						
Man) if sh	ō	Marriand Tarefo	- Fac-		Hor	A	- C								1 ☐ Yes 2 No	
the 28a-	Director	Maryland Harfo	ora		ПdV	re a	e Grac					10g. Citizen of What Country?				
vith be r	這															
ath v	<u>a</u>	308 Woodduck D					210					USZ				
r de	Funeral	11. Marital Status	12. Was	Decedent E ed Forces?	ver in U.S	. 13	B. Was Deced If Yes, spec	lent of H cify Cub:	lispanic Or an, Mexica	rigin? (Spec ın, Puerto F	cify Yes or N Rican, etc.)	0-		- Ame , White	rican Indian, e, etc.	
affe affer a	正	1 ☐ Never Married 2014 Marr	l If Ye	Yes 2X Nes, Give	0		1 ☐ Yes	No No	Specify	:			Specify:			
be filed within 72 hours after death with the Manylar tial Hygiene. dother than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	ρ	3 Widowed 4 Divorced	Yea	r or Dates:			-							W.	hite	
72 h	Completed	15. Deceden (Specify only higher	t's Education	eted)	- 1	16a. Dec	edent's Usua	al Occup	ation	st of workin	a	1	(ind of Bus		•	
Med "	를	Elementary/Secondary (0-12)	-	ege (1-4or 5+	-)	Den	ve kind of wo DO NOT us uty Di	e retire	for o	f	9	U.S	3. Dep	pt.	of	
the the	6			2	Ĺ I	Bud	geting	& 1	Finan	ce		Agr	cicul	tur	e	
Hyge ent,	Be C	17. Father's Name (First, Middle,	Last)				, ,			18. Mother's Name (First, Middle, Maiden Surname)						
d be ental		George Charles	. 7 immor	cor					Max	z Pol	and St	-11201	ic			
nark	은	19a, Informant's Name/Relations				10h Mai	iling Address	(Stroot		_				toto 7	Zin Cada)	
is a fixed year to a factory of the Manyland and 2 should be filed within 72 hours after death with the Manyland setth and Mental Hygiene. In 27 is marked other than "natural", or Items 23a or 28a-f show her traumatic event, the Medical Examiner must be notified at				ι)			-									
and and ealth		Susanne C. Zimm	erer		lan si		Wooddu			<u> </u>						
of H roti		20a. Method of Disposition 1 ☑Burial 2 ☐Cremation	3 □Removal	from State	20b. Pla	ace of Disp metery, cr	position (Nar rematory or c	ne of ther pla	ce)	Da	ate	20c. L	ocation - C	City or	Town, State	
Pag Pent Int: I		4 □ Donation 5 □ Other (S		nom otate	Dar	lina	ton Ce	mete	erv :	8-30-	07	Dar	-linat	ton	, Maryland	
mit.		21. Signature II weral Service	License		, 201		McComa	d-Addre	SS OF FACI	ity Hom	e. P.Z	١.			,	
permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic events.		1/1	Min										n Mai	m/1.	and 21009	
		23a Part1 Fater the disease or	complications	that caused :	the death.								1, 1.84.	<u> </u>		
		23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause	P		1/	- /			,	.copato.y				Approximate Interval Between Onset and Death	
Physician		Immediate Cause (Final disease or condition	_a.	Nepa	itoc	ello	1/41	C	areir	rong					montas	
/Medical		resulting in death)	Di	ue to (or as a	conseque	ence of):										
Examiner		Sequentially list conditions	b													
. **	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Di	ue to (or as a	conseque	ence of):										
uted d ansi	Examiner	Cause (Disease or injury														
exec n an ial-tr	Exa	resulting in death) Last	D	ue to (or as a	conseque	ence of):										
buri																
phy:	Physician/Medical		u													
ding Se as	/Me	IF FEMALE:	23c If ve	s, outcome p	of pregnan	ıcv							00-l D-l-	-6-1-1		
ath o	jan	23b. Was decedent pregnant in the past 12 months?	1 🗆	Live birth 2	2 ☐ Fetal o	death 3	B □Ectopic p		у				23d. Date Mon		Day Year	
he a	Sic	1 ☐ Yes 2 ☐ No		Pregnant at t Unknown	time of dea	ath 5	Other (sp	ecity) _							,	
at the	h	9 □ Unknown														
s the	by	Part II. Other significant condition	ons contributing	g to death bu	t not result	ting in the	underlying o	ause giv	en in Part	1.	23e. Did	tobacco	use contrib	bute to	the cause of death?	
requires t											1 🗆	Yes 2	No 3	3∏ Pr	robably 4 Unknown	
v rec	ete										24a. Wa	s an	24h W	loro ai	utopsy findings available	
e lav has	du										auto	opsv	l pr	ior to eath?	completion of cause of	
Th Dage	Completed										1□ Yes	formed? 2 X No	0 1	☐Yes	2 □ No	
ctor,	Be	25. Was case referred to medica examiner?							26. Plac	e of Death	(Check only	one)				
nysic nis ca dire	2	1 ☐ Yes 2 No	Hospital:	1 🗆 Inpatier	nt 2 □ E	R/Outpati	ent 3 DC	Oth Oth	ner: 4□N	ursing Horr	ne 5□Res	sidence	6 Other	r (Spe	city) hospice	
g P. G		27. Manner of Death		Date of Injury (Month, Day	y Vear)	28b. Time Injury		8c. Inju	ry at	2	8d. Describe	how inju	ury occurre	d		
e fer it it it it is it	tio	1 X Natural 5 ☐ Pendin 2 ☐ Accident investi	ng gation	(Irionan, Day	7001)	nijary	M		Yes 2□]No						
dea dea	fice	3 Suicide 6 Could		Place of inju	ry - At hon	ne, farm, s	street, factor	, office		2				r or Ru	ural Route Number,	
affer Dire	Certification:	4 ☐ Homicide determ	iiilou	building, etc	. (Specity)						City or To	own, Stat	e)			
plta ours eral		29a, Certifler Pertifyir	ng Physician:	To the hest o	f my know	ledge de	ath occurred	at the ti	me date a	ind place a	nd due to the	e cause(s	s) and man	ner as	stated	
Hos 24 hc Fun fely	lica		Examiner: On	the basis of	examination										e to the cause(s)	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical			I manner stat			200	Licens	se number			204 0	ata ciasad	(AAnnt	h Day Voorl	
70 Wit	-	29b. Signature and title of certifie	_				290	, Liberts	58	302		A .	are signed	(WOIL	h, Day, Year)	
~		- grand	Lus					1				M	7USI	a	o ace	
1 / Y		30. Name and address of person	who completed		ath (Item :	23a) (Type	e, Print)	,							4	
10		AMON I C	HALIR	no	67	01/	V. Cl	w	les	ST	Towsi	NI	200	12	6 2007 04	
, S	ate	31. Date filed (Month, Day, Year)	T	32. Registra	r's Signați	ure	1 .0 .									
Regis		AUG 3 1	2007	ALE LIAGO	0 13	63	Marks &									

1 - For State Registrar

Physician

State of Maryland / Department of Health and Mental Hygien 2007 27978 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 3:15 P M ALLAN JULY 2007 MARYLAND Η. 14, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **CUMBERLAND** ALLEGANY DEVLIN MANOR NURSING HOME If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 6. Sex **Funeral** 1 ☐ M 2 🖫 F MARYLAND 217-18-4168 Director 86 17,1921 Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28e-1 show other traumatic event, the Macdical Examiner must be notified at 1 ☐ Yes 2 🙀 No Director MD ALLEGANY CUMBERLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 30 POTOMAC STREET 21502 U.S.A. Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 3 ☐ Widowed 4 ☑ Divorced WHITE 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER **HOME** permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be NETTTE WILLIAM LEE HOUSE TWTGG 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDWARD R. ALLEN, III / SON 1104 WESTERN COLLEGE RD, CEDAR RAPIDS, IA 52404 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CUMBERLAND CREMATORY 07/16/2007 CUMBERLAND, MD 21. Signature of Funeral Service Licenses UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 241 **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Completed by Physician/Medical Examiner The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy be detached for in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown δ Signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 TYes or Attanding Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4-Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this s after death.

I Diractor: After this d in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 16,2007 76017565 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 L2 V212 J Bolline 922 112+ 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 3 1 2007 Registrar

Physician /Medical Examiner Examiner

Department of Health ar Important: If Item 27 is any injury or other trauonce.

Physician

/Medical

Examiner

Funeral

Director

28a-f show notified

23a or must be

7 is marked other than "natural", or items traumatic event, the Medical Examiner mu

n and Mental Hygiene.

death

filed within 72 hours after

pe 1

Pages 1 and 2 should

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

Be

2

MD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Division or Vital Records, P.O. Box 68760, physician the use for After within 24 hours after death

To the Funeral Director;
completely filled in by the

Physician/Medical

Be Completed by

Certification: To

Medical

Part II.

Other significant conditions on the conditions of the conditions o		ot resulting in the und	erlying caus	e given in Part I.	23e. Did tobacco u 1 ☐ Yes 2 [se contribute to the ☐ No 3 ☐ Probal
inertera	Type 12 Mol	bid o	bos	Seles	24a. Was an autopsy performed?	24b. Were autops prior to comp death?
as case referred to medical	1			26. Place of Death (C	heck only one)	
aminer? ⊒Yes 2 ⊉ No	Hospital: 1 Inpatient	2 ER/Outpatient	3□ DOA	Other: 4 Nursing Home	5 ☐ Residence 6	3 ☐Other (Specify)

1	1 ☐ Yes	2] No	3∏ Pro	bably	4 Donki	nown
	Was an autopsy performed es 2	? X 0	24b.	Were autoprior to codeath?		dings ava on of caus	ilable e of
heck of	nlv one)						

27. Manner of Death
1 Natural
2 Accident
3 ☐ Suicide

4 Homicide

5 Pending investigation 6 □ Could not be 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier

Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

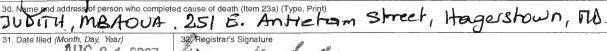
29c. License number D62588

29d. Date signed (Month, Day, Year) August 22 nd, 2007

State Registrar

5

, MBAOUA 31. Date filed (Month, Day, Year) AUG 3 1



		,	1 - For State Registrer	State of Ma	aryland			nt of H te of L		and M		jiene og. No. 2	007	27980
	Physici /Medic		1. Decedent's Name (First, Middle, La Joseph Rudolph A								2. Date of Dea Month August	th Day	_{Уваг} 2007	3. Time of Death 12:45 P M
ζ	Examin		4a. Facility Name (If not institution, given	e street and number) Center			Wes	tmin		of Death		4c. Cour	nty of Death	
	Funeral Director		5. Social Security Number 6. S 230-16-3588 Usual Residence of Decedent	177 M 20 E	9 (In yrs. 12 82	ast birthday) Yrs.	If Unde Months		If Under: Hours	24 Hrs. Min.	8. Date of Birth (Month, Day June 8,	, Year)	9. Birthi Virg	place (State or Foreign In ia
	be filed within 72 hours after death with the Maryland kygiene. At ygiene. do ther then "natural", or iteme 23e or 28e-f ehow event, I're Madical Examinar must be notified at	al Director	10a. State 10b. County Maryland Washing 10e. Street and Number 10116 Sharpsburg			, Town or Lo	10f. Z	p Code 1740			1	0g. Citizen o	of What Cour	10d. Inside City Limits 1 ☐ Yes 2 🔀 No ntry?
2-0036	within 72 hours after deat ene. then "natural", or Iteme ? re Madical Examinal ma	ed by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's E	12. Was Decedent B Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	194	7- '	fYes, spe I⊡Yes	ecify Cuba	Specify:	gin? (Spe i, Puerto	ocify Yes or No- Rican, etc.)	В	lace - Americ lack, White, cify: Whi	etc. †e
8	filed within 72 Hygiene. other then "na ent, It's Medic	e Completed	(Specify only highest gr. Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last	ade completed) College (1-4or 5	+)	(Give	kind of w		luring mosi		ng (First, Middle,	Edu	cation	
ary	2 should and Mer le marke aumetic	To Be	Joseph Rudolph A	Type, Print)			_	s (Street a		er or Rura	il Route Number	r, City or Tow		Code)
e)	permit. Pages 1 and . Department of Health Important: if item 27 eny Injury or other tr		Douglas R. Agee - 20a. Method of Disposition 1 Burial 2 Cremation 3 Communication 5 Other (Special Communication)	Removal from State	Ce	2534 ace of Dispo emetery, cren thsbur	sition (Na natory or g Cr	me of other place ema†c	ory 08	3 –21 -	-2007 S	20c. Locatio	n - City or To	aryland
Da Da	Depar Depar Impor		21. Six ature of Fineral S. 22. 23. Part T. Enter the disease, or comshock, or heaft failure. List only	plications that caused	the death	42	5 S.	Conoc	ochea	ague		lliams		MD 21795 Approximate Interval Between
on,	Cale be executed by Second the partial transit the partial transit the partial transit the partial transit the partial transit the partial transit the partial transit the partial transit the partial transit the partial transit the partial transit the partial transit transit the partial transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to mined ale cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. SEP Due to (or as: b. Due to lor as: c. PECUL	TIC a consequ UM	Stence of): SNIF	to(Onset and Death
Ď	that the death certificate ed by the ettending phys deteched for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal	death 3	Ectopic (oregnancy pecify)					Date of delive	ery Day Year
cords, P	w requires that the been signed by th should be deteche	þ	Part II. Other significant conditions	contributing to death bu	ıt not resu	Ilting in the u	nderlying	cause give	n in Part I.		23e. Did to			he cause of death?
T.	The la ete has page 2	e Completed	25. Was case referred to medical						26. Place	of Death	24a. Was a autops perform 1 Yes	med? 2 No		opsy findings available impletion of cause of
_	Si b	cation: To B	examiner? 1 Yes 2 X No 27. Manner of Death 1 X Natural 5 Pending 2 Accident investigatio	Hospital: 11 Inpatie 28a. Date of Injur (Month, Day	v	ER/Outpatien 28b. Time of Injury		28c. Injury Work	^{RE} 4□Nu	rsing Hor	me 5 □ Reside 28d. Describe he	ence 6 □C		(y)
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	To the Hos within 24 ht To the Fun completely i	Medical	Certifying Pi (Check only one) 2 Medical Example 29b. Signature and title of certifier	nysicien: To the best of miner: On the basis of and manner sta	examinati	ion and/or in	estigatio	n, in my op oc. License	number	th occurr	ed at the time, d	ause(s) and late and place 29d. Date sig	e, and due to	o the cause(s)
			30. Name and address of person who	completed cause of do	M-1	11.0	Print)		51		inster.	8/10	1 07 D 21	157
514	4+1 Sta Registr		31. Date filed (Month Pay Year) 2	349 32. Projistra	ar's Signati	ure A. A	e e	K	(Co	1 9 9 1	1117142	1101	ע ב	/

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Wanda Sirko Daughter 858 Ashburn Way, Woolwich Townshi Your Townshi Your Yo	212 uld be Menta mark		19a. Informant's Name/Relationship (Type, Print)	S (Street and Number or Rura	al Route Number	r, City or Town, State	, Zip Code)
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PitySician Midrical State of the Court of th	Salt ermit Separtr mport njury		Signatur f Funeral Service License 22 Name and Benn	Address of Facility ie Smith Fur	neral F	lome	
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29b. Signature and title of certifier Carc A LOCOL O.C.M.E. August 24, 2007 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	execute in and I - trai	ᇹ	Y IMPENDED Y AMENDED				
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3+VH Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			Carot Hteller	U.U.IVI.E.		August 24, 200	
	3+ VA			, Baltimore, MD 21201			
		te					

ORIGINAL

4410 Bachelons Pf. Ad. OxponD, MO 216541

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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AUG

31. Date filed (Month, Day, Year)

isrouski

M.D.

ORIGINAL

32. Registrar's Signature

Registrar
DHMH 17 Rev 1/2001

State

			1 - For State Registrer	State	of Mar	yland / D	epartn Certifi	nent of H cate of L	lealth a Death	and Me	ntal Hyg R	lene leg. No.	007	27983
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	/Medic		KA the IEEN A				4h	City, Town, or	Location o	of Death	Aug	15 40 Co	2007	3 68 b W
	Examin	er	Howard County		,	al		Colum		, odan				
	Funeral		5. Social Security Number	6. Sex 1		In yrs. last birtl	Mo	Jnder 1 Year Inths Days	If Under 2	24 Hrs. 8. Min.	Date of Birth (Month, Day)	Year)	9. Birthp	lace (State or Foreign
	Director		216 68 2578 Usual Residence of Decedent		52	2 ,	rs.			Ma	ay 22,	1955	Mary	Tand
	yland now at		10a. State 10b. County	/	1	0c. City, Town	or Location	n					1	0d. Inside City Limits
	e Mar 8a-f sl	ctor	MD Howar	d	E	Ellicot	t Cit	У						1 ☐ Yes 2 ZiNo
	a or 2	Dire	102.61 Throughout	Dood			10	of. Zip Code 21042	2		1	-	of What Coun	•
	ns 23	Funeral Director	10261 Tuscany 11. Marital Status	12. Was De	cedent Eve	er in U.S.	13. Was I			gin? (Specif	v Yes or No-		ted Sta	
٥	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at		1 ☐ Never Married 2X Mar	Armed F rried 1 ☐ Yes If Yes, G	2 XNo			Decedent of Hi s, specify Cuba ∕es 2⊠No	n, Mexican Specify:	i, Puèrto Rio	can, etc.)		Black, White,	
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e,	es 1 al of Hea item		20a. Method of Disposition			20b. Place of cemetery				Date			ion - City or To	
Ĕ	Pages ment of ant: If its ury or o		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3		State	St. Jo	hns C	emeter	У				ott Cit	-
Baitimol	permit. Pages Department of t Important: If ite any Injury or of		21. Signature of Funeral Service	- Licensee	M(01044				_	_			ly FH Inc. MD 21043
ř			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that t only one cause on	caused th	e death. Do no								Approximate Interval Between
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Š	The law requires that the death certificate be executed ite has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	itcome pf	pregnancy □Fetal death	2 □Eoto	pic pregnancy				23d	. Date of delive	ry
	ne dea the att hed fo	sicia	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		nant at tin	ne of death		er (specify)					Month	Day Year
Ţ.	that the ed by detacl	P.	Part II. Other significant condition	ions contributing to	death but r	not resulting in	the underly	/ing cause give	en in Part I.		23e. Did tol	bacco use	contribute to th	e cause of death?
Spros	quires n sign lld be	d by	1+	nemic	λ	_					1 🗆 Y	es 2	No 3∐ Prob	ably 4 ☐Unknown
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	The page	Som									autops perfori 1∐ Yes		death?	npletion of cause of 2 □ No
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5	inding ath. r: Afte ie fune	atior	1 Natural 5 ☐ Pendii 2 ☐ Accident investi	ng (<i>Mo</i> . igation	nth, Day Y	<i>ear)</i> Inj	ury	28c. Injury Work 1 1 □ \	k? Yes 2∐1			,,		
<u> </u>	r Atte ter dea irecto irecto	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Plac	e of injury ling, etc. (- At home, farr Specify)	n, street, fa	actory, office		28f	Location (St City or Town		lumber or Rura	Route Number,
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2.	edical	(Check only 2 Medical one)	Examiner: On the	basis of ex nner stated	camination and	or investig	gation, in my op	pinion, dea	th occurred	at the time, d	late and pla	ace, and due to	the cause(s)
	To ti To ti	Σ	29b. Signature and title of certific					29c. License	e number	74	2	9d. Date s	igned (Month, i	Day, Year)
\	a l			17/4				1)	/	10		HU	G, 16	Day, Year) TOOT MD 21045
) (رو	~ ~		30. Name and address of person TAMES Offo, M	who completed cau	Se of deat	n (Item 23a) (T	ype, Print) /OC //	Jaki L		o.fe	N	. /	6.	MA 21040
	Sta		31. Date filed (Month, Day, Year,	32.	Restrar's	Signature		17-1 \ (-1)	41	-116	10,00	<u> </u>	014 1	100,013
	Registr	ar	AUG 2	U 2007	GE 324	w H.	Spe	de						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2007 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 7:20 ^{ам} Charles Robert Bassford August 17, 2007 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Randolph Hills Nursing Home Social Security Number 6. Sex 7. Age (Montgomery Wheaton
If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days tX□M 2□F Hours Yrs Director 579-34-8560 81 June 25, 1926 Washington, DC Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits notified at 1 ☐ Yes 2 ☐ No Maryland Montgomery Silver Spring Direct fhe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö must be 15301 Wallbrook Court, #1G 238 20906 death USA Funeral or Items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. the Medical Examiner Amed Follows: NEWYes 2 No If Yes, Give Year or Dates 1946 - 47 filed within 72 hours affer 1 Never Married 2 Married Maryland 21215-0036 þ 1 ☐ Yes 2√ No Specify 3. Widowed 4 □ Divorced Specify: White "naturel" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Technical Supervisor Magazine Publishing other other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be if Health and Menfal Item 27 is marked o Peges 1 and 2 should be Robert M. Bassford ပ Caroline Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Susan Urso/Daughter 25433 Oak Drive, Damascus, Maryland 20872 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of the Importent: If Ite any injury or ot once. August 24 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union Cemetery 2007 Leesburg, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility nnemary Francis J. Collins Funeral Home Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

500 University Blvd, W., Silver Spring, MD 20901
Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Parkinson's Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed as the burial-transit Due to (or as a consequence of) Box 68760. affending physician Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Day Year 5 Other (specify) P.O. ☐Yes 2☐No defached 9 Unknown The law requires that the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by page 2 should be 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Prostate Cancer been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificafe 2 No 1 Yes 2 No 1 🗌 Yes of Vital Attending Physician: rector 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient William Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA funeral dir fhis 27. Manner of Death 28b Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Affer Division 1 Natural 5 Pending deafh. investigation M 1 Tyes 2 No the f 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 0 Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) d56691 August 17, 2007 DUL Tung /v xi (Item 23a) (Type, Print) 30. Name and address of person who completed cause of d 12107 Heritage Park Circle, Silver Spring, MD 20906 Ghousia Sultana, M.D. 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State AUG 2 0 2007 Registrar

DHMH 17 Rev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 12, 2007 12:52 p^M Florence Bennett Mary August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Frederick Calvert Calvert Memorial Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 28,1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F 88 Director 507-14-2723 Kansas Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County r 28a-f sh notified 1 ☐Yes 2 X No Calvert Owings MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r items 23a or 2 iner must be n 20736 U.S.A. Haley's Way 2135 Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: white 3 Widowed 4 □ Divorced Year or Dates: 'natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government auditor Department of Health and Mental Hygi Important: If item 27 Is marked other any injury or other traumatic event, tl once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pitner Mary ဂ Theodore Barenberg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2535 Chaneyville Road, Owings, MD 20736 Mary Jean Chaney, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Macremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 08-14-07 Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home, P.A. 24. Signature of Funeral Service License 8325 Mt. Harmony Lane, Owings, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYCCARDIAL INFARCTION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FIBRILLA MON 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? 2 No the Hospital or Attending Physiclan: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 ANatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide vithin 24 hours and To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

GLYNIS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 15

2007

110

Registra Signature

29c. License number

050233

HOSPITAL RD, SVITE 310 PRINCE FREDERICK, MO

	 Decedent's Name (First, M 	fiddle. La.	st)						2. Date of De	ath			3. Time of Death
ician	DORIS AVA BEN								Month AUGUST	Day 15		Year 2007	22:56P
dical niner	4a. Facility Name (If not instit			mber)		4b. City, Town, o	or Location		1100001			of Death	
	ANNE ARUNDEL	MEDI	CAL CEN	NTER		ANNAPO	LIS			A	NNE	ARUN	DEL
al or	5. Social Security Number 215–18–6261		Sex I∏M 2 X F		yrs. last birthday 84 Yrs.	If Under 1 Year Months Days		Min.	8. Date of Bir (Month, Da AUGUST	th 17. Year) 26, 1	1922	9. Birthp Cour MARY	place (State or Foreig htry) LAND
	Usual Residence of Deceden			10c	. City, Town or L	ocation						1	0d. Inside City Limits
tor	MARYLAND QUE	EN A	NNE'S		CHESTER								1 ☐ Yes 2 📉 No
Director	10e. Street and Number					10f. Zip Code				10g. Citi	izen of \	What Cour	ntry?
	206 MERGANSER	COU	TRT			21619				UNI:	TED	STAT	ES
by Funeral	11. Marital Status 1 □ Never Married 2 □ □ 3 ☑ Widowed 4 □ Divor		12. Was Dec Armed Fo 1 Tes If Yes, Gi Year or D	orces? 2 📉 No ve	in U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	an, Mexica	n, Puerto F	cify Yes or No Rican, etc.)		Blac	e - Americ ck, White, V: WHI	
ted	15. Dece	edent's Ed	ducation		16a. Dece	edent's Usual Occup	pation			16b. Ki	ind of Bu	usiness/In	dustry
Completed	(Specify only his Elementary/Secondary (0-1)		College (1-4or 5+)	life.	kind of work done DO NOT use retire	id)	st of workir	ng				
	12	(-//- /			OWNE	R/OPERATO						CAM S	TORE
Be	17. Father's Name (First, Mid		,						(First, Middle		Suman	10)	
Jo	GEORGE TAPMAN 19a. Informant's Name/Relat		Type Print)		19h Mail	ing Address (Street			ROUTE Numb		or Town	State Zin	Codel
	ELAINE BENTLE			пснтг									AND 21638
	20a. Method of Disposition	i Dr	TRIDIDE		b. Place of Disp	osition (Name of		AUGUS!				City or To	
	1 XBurial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe					matory or other pla	(CO)	200		CDOL	MCW	TTTE	MARYLAND
	23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	e, or com List only	a. Cause on e	each line.	death. Do not en	ter the mode of dyn	ng, such as				RYLA	ND Z	Approximate Interval Between Onset and Death
by Physician/Medical Examiner	Immediate Cause (Final disease or condition	List only	a. Due to Due to Due to Due to Due to Due to	(or as a con	asequence of): asequence of): asequence of): asequence of): asequence of): asequence of):	der the mode of dying the mode of dying the mode of the mode of dying the mode of the mod	CK RO, ng, such as	cardiac or	23e. Did t	obacco u	23d. Dat Mo	te of delivernth	Approximate Interval Between Onset and Death O
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edical Certification; To Be Completed by Physician/Medical Examin	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	dical dical dical dical examined son who son who	Due to Du	(or as a con (or as a con (or as a con (or as a con toome of pre birth 2 frant at time own eath but not compatient of Injury th, Day Yea of Injury - A ing, etc. (Sp	death. Do not en a sequence of): desequence e return of the course of th	y 26. Place Place Yes at Nury Yes 2 me, date ar popinion, dea	e of Death ursing Hom	23e. Did t 1 24a. Was autoperformed in Yes (Check only of City or Tound due to the	obacco u es 2 [an obsy one) dence (how injury Street and wn, State, cause(s) date and	23d. Data Mo use control No 24b. \(\) \(te of deliverenth all problems of the control of control of the co	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death? Party Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Hollow Da	

DHMH 17 Rev 1/2001

27987 State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 17 Day Month 2007 **Physician** Frederick William Brennan 8 8:50 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Worcester Atlantic General Hospital Berlin If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country)
 D.T. 6. Sex 7. Age (In yrs. last birthday) Funeral 1**X** M 2 □ F Yrs. Director 035-14-0503 84 3/30/1923 RΤ Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No. Worcester Ocean City 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? the Medical Examiner must be 21842 USA 10700 Coastal Hwy. Unit 304 items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 DXYes 2 No If Yes, Give WWII Year or Dates: WWII 1 Never Married 2K Married ŏ 1 ☐ Yes 2X No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced "naturai", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) US Government Computer Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of John Frederick Brennan Catherine McCusker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i 1050 Yonge St., Toronto. Ontario, Canada M4W2LI Joe Brennan / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of He
important: If iter
any injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/21/2007 Gate of Heaven Cem. Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Pervice License 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic ung **Physician** Cancer /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 DEctopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? 1□ Yes 2□ No within 24 hours after death.

To the Funeral Director: After this certific Be 25. Was case referred to medical examiner? 26. Place of Death [Check only one] Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☑ No Hospital: Certification: To 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death conumed at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)53612 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M 972 Healthway In Prin MD 21811 BASH Indrea & Baier 31. Date filed (Month, Day, Year) 32. Ragistrar's Signature State Stewar It Specie

DHMH 17 Rev 1/2001

Registrar

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Don:

NOB: 3130123

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Box 68760

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Records,

Division of Vital

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 200⁷7 Emilv Christopher Aug. 5:37 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline Home for Hospice Denton Caroline If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □ X 101 216-18-2628 Director June 10, 1906 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD 1 ☐ Yes 2 ▼ No Caroline Director Preston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21100 Marsh Creek Road 21655 United States Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be flied i Department of Health and Mental Hygid Important: If item 27 Is marked other any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Sadie E. Williamson Phillip Hopkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Edna Hart/ Daughter 22303 Tanyard Road, Preston, MD 21655 20b. Place of Disposition (Name of cemetery, crematory or other place)
Junior Order Cem. 20a. Method of Disposition 20c. Location - City or Town, State 1 I Burial 2 ☐ Cremation 3 ☐ Removal from State 08/29/07 Preston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. Federalsburg, MD 21632 21. Signature of Funeral Service Licensee Muhail 7 Federalsburg, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** squamous cell carcinoma of 6 months /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trar that the death certificate be execu and Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ disease Corona 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed 1∐ Yes 2 🗔 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Division or Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 9c. License number D64973

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) man nie D.

215 Bloomingdale Rederalsburg MD

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 5:00 Cardona Bertha August 16, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 624 Whispering Wind Court Montgomery Gaithersburg If Under 1 Year | If Under 24 Hr Months | Days | Hours | Mir 8. Date of Birth (Month, Day, Year) 5. Social Security Number . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 👽 F 73 Yrs. 263-74-3381 Director Sept. 19,1933 Cuba Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. Health and marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 20877 624 Whispering Wind Court United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1XIYes 2□ No Specify: Cuban White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) the 12 Administrative Assistant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Luis Perez Bertha Pazos ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a
Department of Health ar
Important: If item 27 is
any injury or other trau Carlos Cardona / Husband 624 Whispering Wind Court, Gaithersburg, MD 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State August 2007 22 Gate of Heaven 4 Donation 5 Dother (Specify) Silver Spring, MD 21. Signature of Funeral Service Lice is 22. Name and Address of Facility DeVol Funeral Home RACI uver 10 East Deer Park Drive, Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Gall Bladder Cancer 6 Months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be executed Examir and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐XNo Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an was and autopsy performed?
Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 27. Manner of Death 1 ZNatural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) D0033293 August 17, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Frederick P. Smith,

AUG 2 0

31. Date filed (Month, Day, Year)

5454 Wisconsin Ave. #1300, Chevy Chase, Md. 20815

7-06629 Dennis Richard	Chu	Please Type or Print in Black Indelible rchey State of Maryland / Department		_		
		1- For State Certificate		Reg.		7 2799
Physici Medical Exami		1. Decedent's Name (First, Middle,Last) Dennis Richard Churchey		August 26, 2		3. Time of Death 2037 hrs
		4a. Facility Name (if not institution, give street and number) 9619 Morning Glory Iane	4b. City, Town, or Location of Deat Hagerstown	h	4c. County of Death Washington	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 15-92-8730 1X M 2 F 42	Yrs. If Under 1 Year If Under 24Hr Months Days Hours Mi	_	MM/DD/YYYY) g. Birt Foreig ,1965 C体	hplace (State or n l햄까y l and
v any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
Maryland 28a-f show d at once.	ctor	Maryland Washington	Hagerstown	T 10a	Citizen of What Cour	1 Yes 2 XXNo
h the Ma 3a or 28	I Dire	9619 Morning Glory Lane	21740		USA	
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must he noiffed at once	Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Mo 3 Widowed 4 Divorced If Yes, Give Year 1	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert Yes 2 X No specify:		14. Race - Americ White, etc.	
iours aft natural" 'Xamine	ed by	Lor Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent grade completed	edent's Usual Occupation (Give kind of a most of working life. DO NOT use re		Specify: 6b. Kind of Business/li	White ndustry
5-0036 led within 72 h Hygiene. other than "n the Medical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Driver	,	weeping Conti	ractor
21215-0036 suld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, Last)		e (First, Middle, Mai Mae Hen	,	
AD 21215-0036 2 should be filed within h and Mental Hygiene. 27 is marked other tha matic event, the Medic	To Be		Elva Giling Address (Street and Number or	Rural Route Number	er, City or Town, State	
			Morning Glory La		stown, Mar	
more		1 XX Burial 2 Cremation 3 Removal from State crematory of	or other place)		ŕ	g, Ma r yland
Baltimore, permit. Pages 1 ar Department of Hes Important: If ite injury or other tr		21. Si cation Funeyal Service Licensee 2	Ostre masdorsum ender H	ome, P.A.		
Physician	- 0	Zast Part I. Enter the disease, or complications that caused the death. Do not en	425 S. Conocochea ter the mode of dying, such as cardiac			Approximate Interval
/Medical xaminer		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	ad			Between Onset and Death
		Sequentially list conditions,				
	Examiner	if any, leading to immediate cause. Enter Underlying Causes (Disease or injury that initiated				
xecuted n and I - transit		events resulting in death) Last Due to (or as a consequence of):				
O, be exectivities of the objection of the original original of the original original original original original original original original original original original original original origi	edical	UNPENDED X AMENDED 28f, perME.g871. 9/5/0)7. TT			
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic pregr	ancy	23d. Date of delivery Month E	yay Year
hed hed	Phys	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I	23e. Did toba	cco use contribute to	the cause of death?
F, P.C ires that signed b	by				2 No 3 Prob	
Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be rs after death. al Director: After this certificate has been signed by the attending physicifed in by the funeral director, page 2 should be detached for use as the buri	Completed			24a. Was an autopsy perform	prior to death?	topsy findings available ompletion of cause of s 2 No
Vital Rechysician: The this certificate	Be	25. Was case referred to medical examiner? Hospital: Inpatient 2 ER/Outpal	26.Place of Death (Checklient 3 DOA Other Nurs		esidence 6 🗸 Other	Scene
Sion of Vital I Vitending Physician: death. crtor: After this certifi by the funeral director,	ition: To	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) Unknown 28b. Time Unknown	of Injury 28c. Injury at Work?	28d. Describe how Subject shot s	v injury occurred	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	2 Accident Investigation 3 V Suicide 6 Could not be determined (Specify) Townhouse / Rowh		Location (Street) For Town, State 19012 Morning G	eet and Number or Ru e) lory Lane, Hagersto	ral Route Number, City own, MD
To the Ho within 24 P To the Fu	Medical	29a. Certifier (Check only one) 2 ✓ Medical Examiner: On the basis of examination and/or inves				
To To COI	Me	and manner stated. 29b. Signature and title of certifier	29c. License number		9d. Date signed (Mor	oth, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		August 27, 2007	
		Zabiullah Ali, M.D. Assistant Medical Examiner 111 F	Penn Street, Baltimore, MD 2	1201		
Si Regis	tate trar	31. Date filed (Month, Day, Year) AUG 2 8 2007 32. F distrar's Signature	ocate			

DOME

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Cecil (NMN) Campbell August 17 2007 6:45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington County Julia Manor Health Care Hagerstown 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year, Months Days Hours 1 XM 2 □ F Yrs. 216-14-5027 April 8 1927 Director 80 Maryland Usuel Residence of Decedent death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 77 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be redified at 1X Yes 2 □ No Hagerstown Washington Maryland Directo 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? U.S.A. 21742 962 Apt A Security Road Funerai permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic even." 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🗓 No Specify Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done di life. DO NOT use retired) during most of working (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Turners Cab Company Taxi Cab Driver unknown 18. Mother's Name (First, Middle, Maiden Sumame)
Flora Bell Stribling Campbell 17. Father's Name (First, Middle, Last) Be Theodore Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris J. Campbell - wife 962 Apt A Security Rd. Hagerstown Maryland 21742 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State placel 1 Burial 2 □ Cremation 3 □ Removal from State Rose Hill Cemetery Aug 23 2007 Hagerstown Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742 ron 23a. Part 1. Enter the disease, or complications that reused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician 165 Cancer Jate /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner signed by the attending physician and deedetached for use as the burial-transit law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Hnknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 2 🗆 No 1 Yes Division of Vital 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: al or Attending F s after death. I Director: After d in by the funera After 1 Waturai 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 62-20-2067 225 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 Opal Court, Hagerstown, MD Dr. Waseem 21740 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 1 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. Amended #20b, nls, 08/10/07, Allegany Co. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 **Physician** 08 02 1133 MARY LOUISE CARR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS - MEMORIAL CAMPUS CHMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 □ F 74 NORTH CAROLINA Director 23,1933 223-44-4119 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director WV HAMPSHIRE SPRINGFIELD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26763 U.S.A. HC 65, BOX 3460 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No þ Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOME 12 traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item 27 Is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be ERNEST CLYDE PERRY ELIZABETH MARIE MELSON 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HC 65, BOX 3420, SPRINGFIELD, WV WILLIAM CARR / HUSBAND 26763 Baltimore, 20b. Place of Disposition (Name of cametery, crematory or other place)

CUMBERLAND 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CUMBRLAND CREMATORY CUMBERLAND, MD 21. Signature of Funeral Service Liberates 22. Name and Address of Facility UPCHURCH FUNERAL H 202 GREENE STREET, nucle 21502 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SHOCK WLEK /Medical Due to (or as a consequence of): Examiner ACT INFECTION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 WNo Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DZ5406

> State Registrar

WILLIAM

31. Date filed (Month, Day, Year) AUG 1 0 2007

DHMH 17 Rev 1/2001

Seton Dr., CUMBERLAND ND 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAMM

900

2. Registrar's Signature

DHMH 17 Rev 1/2001

		1	For State Registrar		or iviaryia		ertifica				Reg. No. 2	007	27994
Phys	iciar		Decedent's Name (First, Middle	, Last)	-		Q1	1		2. Date of De	Day	Year	3. Time of Death
	dica	. 1	Nellie 4a. Facility Name (If not institution)	give street and n	Irene		_	mber	S Location of Dea	August		nty of Death	6:15 P M
Exar	IIIIIe		Beverly Living	_		and			berland			Allega	ıny
Funer Direct			5. Social Security Number 341–16–1449	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs	. <i>last birthd</i> a Yrs.	y) If Unde Months	Days	If Under 24 Hr Hours Min		h y, <i>Year)</i> 1912	9. Birthpl Count Kentu	lace (State or Foreign try) Cky
and	e.	-	Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or	Location					10	0d. Inside City Limits
ne Maryli 8a-f sho otified at			MD	Allegany				mber	land				1 ∐Yes 2 MNo
3a or 2		בה ה	10e. Street and Number 13426 Ro	ckv Gan	Road. N	E	101. 21	p Code 2	1502		rug. Citizen	of What Count	iry?
DENILITIONEY, INIGITY ISING ZIZIO-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifited at		2	11. Marital Status 1 □ Never Married 2 □ Marri	12. Was De	cedent Ever in			edent of H ecify Cuba	ispanic Origin? an, Mexican, Pue	(Specify Yes or No erto Rican, etc.)		Race - America Black, White, e	
hours af tural", or al Exami		ል	3 ₩ Widowed 4 Divorced	If Yes, 0 Year or	Bive 11 Dates:		1 🗌 Yes	2X No	Specify:				nite
n 72 h "natu ledical		Completed	15. Decedent (Specify only highes			16a. Ded (Gir life	edent's Usi ve kind of w . DO NOT i	ual Occup ork done duse retired	ation during most of w f)	orking	16b. Kind of	f Business/Ind	lustry
d with giene.		Ę	Elementary/Secondary (0-12)	College	(1-4or 5+)	Se	amstr	ess			Clo	thing	
/land uld be file Mental Hy trked othe	6	e n	17. Father's Name (First, Middle, I			M - LIL				ame (First, Middle,	Maiden Surr	-,	
ryia thould to Mer marke matic	ŕ	2	John 19a. Informant's Name/Relationsh	Wilson			orter		Ann	Rural Route Numbe	er. City or Toy	Moran wn State Zin	
INICAL Ind 2 sl alth an 27 is r			Dorothy B. Wall		ister		_			, NE., Cu	-		*
ore, jes 1 au of Hea if item or othe			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from	I .	Place of Dis cemetery, co	position (Na rematory or	me of other plac	ce)	Date	20c. Locatio	on - City or To	wn, State
DallIIIOO Dermit. Pages Department of mportant: If it			4 Donation 5 Dother (St. 21. Signature of Funeral Service I	pecify)	St	ınset	Memor	ial F	Park 08/	15/2007	Cumb	erland,	• MD
Depa Depa Impo	ouce		21. Signature of June 1 Service I	(). ().	lener.					dams Fam: t, Cumber			Home, P.A.
District			23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that only one cause or	caused the dea each line.	ath. Do not e	nter the mo	de of dyir	ng, such as card	ac or respiratory a	rest,	MD	Approximate Interval Between Onset and Death
Physicia /Medic	_		disease or condition resulting in death)		ongesti o (or as a conse		rt Fa	ilurc				r	months
Examine	ш.	<u>.</u>	Sequentially list conditions, If any, leading to immediate b. Coronary Artery Disease								n	months	
suted d ansit			Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events C. Hypertension								7	years	
oo / ou, tificate be executed g physician and as the burial-transit		edicai Examiner	resulting in death) Last	Due to	o (or as a conse	quence of):							
ficate be expression of the purificate burial				d									
w requires that the death certiful been signed by the attending should be detached for use a		Physician/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23d. Date of Month 1 □ Company 1 □ Company 2 □ Company 3 □ C								Date of delive Month	delivery Day Year	
uires that signed b	3	2	4 TV OT No. of the state of t										
The lar		Completed	24a. Was an autopsy prior to completion of ca death?									psy findings available inpletion of cause of	
	3		25. Was case referred to medical examiner?						26. Place of D	1 Yes eath (Check only o	2 🔀 No ne)	T Tes	2 140
Or VILA Physician: rthis certific ral director,		2	1 ☐ Yes 2 ☒ No			□ER/Outpati			4 LA Nursing	Home 5 ☐ Resid			0
Attending P r death. ector: After t		ation:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investig	ation (Mo	e of Injury onth, Day Year)	28b. Time Injury		28c. Injur Wor 1 ☐	yat k? Yes 2 ⊡ No	28d. Describe I	now injury occ	curred	
i gige		Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned Zoe. Pla	ce of injury - At ding, etc. (Spec		street, facto	ry, office		28f. Location (8 City or Tox	Street and Nu vn, State)	imber or Rurai	l Route Number,
Lothe Hospital within 24 hours a to the Funeral lotherely filled	100	Medical	29a. Certifier 1 Certifyin (Check only one) 2 Medical i	Examiner: On the	he best of my kr basis of examinanner stated.	nowledge, de nation and/or	ath occurre investigation	d at the tir	me, date and pla	ce, and due to the courred at the time,	cause(s) and date and plac	l manner as st ce, and due to	ated. the cause(s)
o the	1	ME	29b. Signature and title of certifier)	1 15		25	c. Licens	e number		29d. Date sig	ned (Month, I	Day, Year)

State Registrar

31. Date filed (Month, Day, Year) AUG 1 4 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



nas

D0062929

August 13, 2007

07-06553 Jay Cross Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

27995 2007

		1- For State Cer	tificate of Death	Reg. No.	1 6133					
Physici	an/	Decedent's Name (First, Middle,Last)		Date of Death Month Day Year	3. Time of Death					
Medical Exami	ner	cay monas cross		August 24, 2007	0445 hrs					
- al		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		th					
		Civista Medical Center	LaPlata	Charles						
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. Ia	If Under 1 Year If Under 24Hrs Months Days Hours Min	8. Date of Birth(MM/DD/YYYY) 9. B	ign i					
Director		214-02-4934 1X M 2 F 39	Yrs.	12/18/1967	ountry) NJ					
•	alm provides	Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Location		10d, Inside City Limits					
эм ану					1 Yes 2 No					
Maryland 28a-f show 1 at once.	tor	MD Charles H	lughesville							
Mar. r 28a	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	untry?					
th the		2000 COOKE DWEETHEY FIACE	20637	U.S.A.						
after death with the Maryland al", or items 23a or 28a-f sho ner must be notified at once.	neral	11. Marital Status 1 Never Married 2 X Married Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto 		ncan Indian, Black,					
	Fun	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:	Specific Tille						
	્રે	Lor Dates:	16a. Decedent's Usual Occupation (Give kind of	Specify: Whj						
2 hou	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use ret		no. The set all the set of the					
036 thin 7 than than tedics	ď	12	Kitchen Staff	Food Sen	vice					
5-0036 led within 7 Hygiene, other than	ပိ	17. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, Maiden Surname)						
21215-C nuld be filed v Menal Hygi marked oth	Be	Jay N. Cross	Mary A	nn Schafer						
D 21215-C should be filed v and Mental Hygi 7 is marked oth	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or							
MD nd 2 sho alth and m 27 is		Jay N. Cross/Father	200 West Lewis Street							
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ent of Health and Mehral Hygiene. It is firem 27 is mayiked other than "naturiar", rother traumatic event, the Medical Examiner.			Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City of	or Town, State					
				/27/2007 Clinton,						
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumati		21. Signature of the Serving Lirensee	22. Name and Address of Facility Le	e Funeral Home Cal	vert, P.A.					
_ ====	0 1	Michael W. Les	8125 Southern MD B		20736 Approximate Interval					
Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
xaminer	8 1	Immediate Cause (Final disease or condition resulting in death)	ia ·		Death					
		Muccardial tumpo	ling of coronary artery							
	er	if any, leading to immediate Due to (or as a consequence of								
	Examine	cause. Enfer Underlying Cause (Disease or injury that initiated	A							
xecuted n and - transit	Ě	events resulting in death) Last Due to (or as a consequence of d.).							
760, icate be executed physician and the burial - transi	/Medical									
760, ficate be ex g physician the burial	Ned	#23a-b,PII,2/,pe	erME.g871, 9/19/07 TT	23d. Date of delive	rv					
587 ertific ling p	=	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregna		Day Year					
Ox 687 eath certifi e attending for use as t	Physiciar	Pregnant at time of dea	ath 5 Other (Specify)							
that the de ned by the detached f	Ph	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I	23e. Did tobacco use contribute t	o the cause of death?					
, P.C	ρ	Panaroatic adapasardinama abrania na		1 Yes 2 No 3 Pr						
ords, w require as been si	ted	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		24a, Was an 24b, Were a	autopsy findings available					
COF law r has b	n pie	muscular dystrophy status post chole	ecystectomy	autopsy prior to performed? peath?	completion of cause of					
tal Rection: The certificate ector, page	Completed			1 Yes 2 No 1 V	res 2 No					
Vital Rec ysician: The his certificate	Be	25. Was case referred to medical examiner? Hospital: 1 Innatient 2	26.Place of Death (Check ER/Outpatient 3 DOA Other, Nursin							
of Vit Physic er this	L 2	1 Yes 2 No 1 Inpatient 2 2 27. Manner of Death 28a. Date of Injury	ER/Outpatient 3 DOA Outlet 4 Nursin 28b. Time of Injury 28c. Injury at Work?	ng Home 5 Residence 6 Oth 28d. Describe how injury occurred	er:					
n of value Phy. th.	ö	1 X Natural 5 Pending (Month, Day, Year)	1 Yes 2 No	and a second them myary seconds						
Visior or Attend ufter death Director:	<u>iz</u>	2 Accident Investigation	ome, farm, street, factory, office building, etc.	28f. Location (Street and Number or F	Rural Route Number, City					
Divis	Certification:	Suicide 6 Could not be determined (Specify)	,	or Town, State)	, , ,					
T = 5 5 5		29a. Certifying Physician: To the best of my knowledge	ge, death occurred at the time, date and place, and	d due to the cause(s) and manner as sta	ated.					
To the Hos within 24 ho To the Fun completely	at the time, date and place, and due to									
2 € € 6 0	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (M	onth, Day, Year)					
			O.C.M.E. August 25, 2007							
	-	30. Name and address of person who completed cause of death (Item			·					
OCI		Mary G. Ripple MD. Deputy Chief Medical Exan	niner 111 Penn Street, Baltimore, N	/ID 21201						
	ate	/// // // // // // // // // // // // //	re dans							
Regis	trar	HOU NO LOUI	& sperker							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 020/1 Peggy Ann Collins 200 TUQUST /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner -aston HOSPITCH Memorial Talbot If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2**X** F Director 219-62-9832 Oct 14 1954 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Items 23a or 28a-f shov ner must be notified at 1 X Yes 2 □ No Director Denton Caroline Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21629 USA 908B Gay Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: White þ Specify. 3 ☐ Widowed 4 💆 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. Item 27 Is marked other than disabled n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis T. Collins I Mary Elizabeth (unknown) other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 25430 Smith Landing Road; Denton, MD 21629 Ginger Lee Ensley/ daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If its any injury or of 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake CremCen 8/29/07 | Chester, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Fleegle and Helfenbein Funeral Home, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Min Greensboro, MD 21639 Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Curonin that the death certificate be executed Directo for as a consequence of) Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9∏Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>6</u> 201No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed?

1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ☐ ER/Outpatient 3□ DOA Certification: To filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) Rospitalist D66264 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Babak Pirouz, 219 S Washington St. Easton, MD 21601 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

AUG 2 0 2007

Registrar

AUG 15

Baltimore, Maryland 21215-0036

within 24 hours a Medical

N. 31. Date filed (Month, Day, Year) State AUG 1 5 2007 Registrar

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

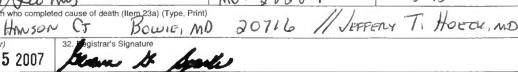
29b. Signature and title of certifier

4175

6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

58289

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

		For State Registrar	Sidie 0	ı ıvıaryla				lealth and l <i>Death</i>		giene Rag. No.	2007	27999
		Decedent's Name (First, Middle, Las	t)			*			2. Date of De	ath	. ٧	3. Time of Death
Physicia /Medic		Donald Cropper							Month 8	Day	6 200	7 1045 M
Examin		4a. Facility Name (If not institution, give	street and nu	mber)		4b. City,	Town, o	r Location of Deat	h	4c. (County of Death	
		Atlantic Genera					1in			1	cester	
uneral		5. Social Security Number 6. So	ex CM 2□F		s. last birthday) Yrs.	If Under Months		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 11/10/	th ay, Year)	9. Birth	place (State or Foreign intry)
rector		Usual Residence of Decedent		85	115.				11/10/	1921		MD
=		10a. State 10b. County		10c. 0	City, Town or Lo	ocation						10d. Inside City Limits
pal	ţo	MD Worces	ter	W	halleyv	ille						1 ☐ Yes 21 No
eny injury or other treumatic event, the Medical Examiner must be notified at once.	rec	10e. Street and Number				10f. Zip	Code			10g. Citiz	zen of What Cou	intry?
9	D D	11106 Bell Rd.				21	.872			ľ	JSA	
	Funeral Director	11. Maritaf Status	12. Was Dec	edent Ever in	U.S. 13.	Was Dece	dent of H	lispanic Origin? (S an, Mexican, Puert	ipecify Yes or No)- 1	4. Race - Ameri Black, White	
	F	1 Never Married 2000 Married	1 ⊡xYes If Yes, Gir			1 ☐ Yes		Specify:		i		
	d b	3 Widowed 4 Divorced	Year or D	ates: WWI	I						MIIT	
	Completed by	15. Decedent's Ed (Specify only highest gra			16a. Dece	kind of wo	af Occup nk done	ation during most of word)	rking	16b. Kin	nd of Business/Ir	ndustry
	d m	Elementary/Secondary (0-12)	College (1-4or 5+)			se retiret	u)		Corr	0 m + w17	
	ပိ	17. Father's Name (First, Middle, Last)			Carpe	nter		18. Mother's Nar	ne (First Middle		oentry	
	o Be	Lemuel Cropper							у Сооре		, , , , , , , , , , , , , , , , , , ,	
	ဥ	19a. Informant's Name/Relationship (7	vpe. Print)		19b. Mailir	na Address	(Street	and Number or Ru			Town, State, Zi	p Code)
- 1		Julia Ann Cropper						i., Whale				,
	1	20a. Method of Disposition	/ WIIC	20b.	Place of Dispo				Date		cation - City or T	own, State
1		1 XBurial 2 Cremation 3 4 Donation 5 Other (Specify		State	cemetery, crei vergree				/2007	Ber	lin, MD)
ė l		21. Signiful of Fundal Service Licen			_			ss of Facility	•			
		2 11. 12 1. 11	Mare -					iam St.,				
		23a. Part1. Enter the disease, or comp. shock, or heart failure. List only		aused the de	ath. Do not ent	er the mod	te of dyin	ng, such as cardiac	or respiratory a	rrest,	-	Approximate Interval Between
,		Immediate Cause (Final	one ocuse on e					farcti				Onset and Death
ί		disease or condition resulting in death)	a	(or as a cons					un			
r		and the second second	W-		enal	Fa	ih	ire				
4	Jer	if any, leading to immediate	Due to	(or as a conse	- /		1	Fou				
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	Lon.	estiv.	e H	ewi	fred.	nre		-	
	EX	resulting in death) Last	Due to	(or as a cons	The same of							
1	dical		d1	TY/26	rlen.	51011			_			
- 1	0	IF FEMALE:							-			
1	by Physician/M	23b. Was decedent pregnant in the past 12 months?		ointh 2 ☐ Fe	tal death 3□	∃Ectopic pr		,		2:	3d. Date of deliv	rery Day Year
	Sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregr 9⊟Unkn	ant at time of own	death 5	Other (sp	oecify)				WORKE	Day Teal
l	F.	Part II. Dther significant conditions co	entributing to d	eath but not re	eulting in the u	ndarh in a a		on in Bort I	22a Did	obacco us	na contributa to l	the cause of death?
	<u>5</u>	Tate II. Dated digital delicated as	Sitting to di	Batti Bat not re	sauting in the u	inderlying c	aus e giv	en ar Fait i.			No 3□Pro	
	etec											
l	Completed								24a. Was	psy 🥖	prior to co	opsy findings available ompletion of cause of
									1 ☐ Yes	2 No	death? 1 ☐ Yes	2□ No
	Be	25. Was case referred to medical examiner?	Hospital:				Oth	O.C.	ath (Check only			
	္	1 Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatier		/^	4 🗆 ivuising 🗆	lome 5 Resi			fy)
	- Lo	1 Natural 5 ☐ Pending	(Mon	th, Day Year)	28b. Time of fnjury	M	28c. Injur	yai k? Yes 2 ∐No	28d. Describe	now injury	occurred	
	lica	2 Accident investigation 3 Suicide 6 Could not be		of Injury - At	home, farm, str				28f Location /	Street and	Number or Bur	al Route Number,
	Certification:	4 ☐ Homicide determined	buildi	ng, etc. (Spec	cify)	-5t, (actor)	, 0.1100		City or To	wп, State)		a outo realibor,
		29a. Certifier 12 Certifying Ph	ysician: To the	best of my kr	nowledge, deatl	h occurred	at the tin	ne, date and place	and due to the	cause(s)	and manner as	stated.
	Medicai	(Check only 2 Medical Examone)	iner: On the b	asis of examir	nation and/or in	vestigation	, in my o	pinion, death occu	irred at the time,	date and	place, and due t	to the cause(s)
	Me	29b. Signature and title of certifier				290	c. Licens	e number		29d. Date	signed (Month,	Day, Year)
		Broket A MA	me mi	0 4	Huden	,	705	70312		8/1	16/200-	7
		30. No and address of person who d	completed caus	e of death (Ite	om 23a) (Tvp≕.	rint)		. 1		-11	1000	/
-1		Oregony W.	- in	mnas	11.0	9	7 <i>3</i> 3	Health	inny L	rive	Berl	in, MD
		31. Date filed (Month, Day, Year)	20 0	egistrar's Sign	/				1			

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	iryiand / L		ficate of L			Reg. No	2007	280	000
	Physicia	an	1. Decedent's Name (First, Middle, Last)	Marii 7	mogono	DoF1	3.00		2. Date of De Month	Day		3. Time of	Death P M
4	/Medic	al	4 - Facility Nieuw (16 - 4 in 464 4in - 164 -		mogene		b. City, Town, or	Logation of Dog	Hugust	24	2007 County of Death	1,35	- 141
	Examin	er	4a. Facility Name (If not institution, give si Washington Count		7	"	-	erstown	2011	40.	Washi.	naton	
	Funeral	TA N	5. Social Security Number 6. Sex		(In yrs. last bir		f Under 1 Year	If Under 24 Hr		rth		place (State ontry)	or Foreign
Ľ	Director		220-18-0536 1□ Usual Residence of Decedent	M 2 TF	86	Yrs.	Months Days	Hours Mir	May 1.	3, 19	21 Wes	t Virg.	
	land ow at		10a. State 10b. County		10c. City, Tow	n or Locat	ion					10d. Inside C	ity Limits
	Mary a-f sh ified	햦	Maryland Washing	ton			Hagerst	town				1X Yes	2 □ No
	th the or 28% e not	Director	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What Cou	ntry?	
	23a ust b		145 King Stree			,	217				U.S.A.		
	er de t	Funeral	Tr. Maria Saras	Was Decedent E Armed Forces?		13. Wa	s Decedent of Hi es, specify Cuba	spanic Origin? (n, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	0-	 Race - Ameri Black, White 		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 🔣 Widowed 4 ☐ Divorced	1 □ Yes 2 🔯 N If Yes, Give Year or Dates:	10	10	Yes 2∭X No	Specify:			Specify:	White	
Baltimore, Maryland 21215-0036	72 hou natura iical E	Completed	15. Decedent's Educ	ation	16a	. Deceder	it's Usual Occupa	ation	orkina	16b. Ki	nd of Business/Ir	ndustry	
21	ithin ne.	nple	Elementary/Secondary (0-12)	College (1-4or 5-	+)	(Give kind of work done during most of workin life. DO NOT use retired)			g		- 1		
2	iled w Hygiei ther th		12 17. Father's Name (First, Middle, Last)	· .		A	ssembly	18. Mother's Na	ame (First, Middle		Aircraft		
and	d be f ental h ed of	Be c	John E. Tyson						Luttrel		our manney		
Ž	should nd Me mark matic	2	19a. Informant's Name/Relationship (Typ	ne. Print)	196	. Mailing	Address (Street a		Rural Route Numl		r Town, State, Zi	p Code)	
Š	alth a 27 Is er trau		Ellen I. Kesslerin	g (Daug	hter)	59 G	lenview	Road Sv	vanton, l	Maryl	and 215	6 1	
Jre,	of Hear		20a. Method of Disposition				on (Name of tory or other plac	0)	Date		cation - City or T		
<u>Ĕ</u>	Page ment ant: If ury o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Smiths	burg	Cremato	ory Aug	gust 27, 2007	Smi	thsburg	, Mary	land
3alt	permit. Departi Import any Inj once.										s Funeral Home		
	<u>0</u> □ = @ 0	JAVIS JOINTY 12323 Bladwarg IVC. Briteria										Land 2. Approxima	
			shock, or heart failure. List only one cause on each line.										tween Death
	Physician /Medical		disease or condition resulting in death)	Diev	a consequence	of):						4 DAY	15
	Examiner			2 A	atia -	,	1				1	itens	
	\$4.	Jer	Sequentially list conditions, if dry, leading to limited as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events							- 5	1 125		
3	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events										
9	ficate be executed g physician and is the burial-transit		resulting in death) Last	Due to (or as a	a consequence	of):							
68760,	cate b physic the b	edical	d										
-	certiff nding Ise as		IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome					116		23d. Date of deli	/erv	
. Box	The law requires that the death cer ate has been signed by the attendin bage 2 should be detached for use	Physician/M	in the past 12 months?	1☐Live birth 4☐Pregnant at			ctopic pregnancy other <i>(specify)</i>	'			Month	,	Year
P.O.	at the by the tache	hys	9 Unknown						1				
S, F	es the igned be de	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to th			
ord	requir een s nould	ted			W 10 10 10				7. 7/49	Yes 2		bably 4 🗌	
3ec	e law has b e 2 st	Completed by							24a, Was		24b. Were aut prior to c death?	opsy findings ompletion of o	available cause of
alF	n: The		25.11						1□ Yes	2 🗷 No	1 ☐ Yes	2□ No	·
ΖĦ	Physician: r this certific ral director,	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpatie	 nt 2 □ ER/O	utnotiant	3 DOA Othe	3r.	eath <i>(Check only</i> Home 5 Res		c DOther (See	14.A	
ō	g Phy er this eral d): To	27. Man r of Death	28a. Date of Injur	y 28b.	Time of	28c. Injun	y at	28d. Describe			пу)	
jon	ath. r: Afte	atio	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	r rear)	Injury	M 1 □	<br Yes 2 □ No					
Division or Vital Records,	r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							ff. Location (Street and Number or Rural Route Number, City or Town, State)			
Ω	pital curs af eral Deral Dilled it												
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s and manner stated.									s)	
	To th withir To th comp	Me	29b. Signature and title of certifier	1			29c. License			29d. Da	te signed (Month	, Day, Year)	
			* Ky Ktur	Kan	phsie	-	US	678	5	Ayv	st 27	1005	
	N		30. Name and address of person who co	mpleted cause of de	ath (kem 23a)	(Type, Pr	int)		D()		1.	M. I	1
	7		31. Date filed (Month, Day, Year)	7 O	ar's Signature	VICA	1 (ain	pus V	o wag	Cr5	TUWI) 1	'laryle	2110
	Sta Registr		AUG 3 1 200	Tales.	1	Spire	W.		•				
				No.		-							

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